

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00974

00972

1. DECEASED-NAME (Type or print) Lillian Mae Banks			2a. DATE OF DEATH Month 1 Day 30 Year 68			2b. HOUR 9:30 PM					
3. SEX Female		4. RACE Colored		5. DATE OF BIRTH 9-1-1907		6. AGE (In years last birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.					
10. CITY OR TOWN OF DEATH Harre de Grace			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Harford Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cook			12b. KIND OF BUSINESS OR INDUSTRY Restaurant		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER P.O. Box 171		
14. FATHER'S NAME First Lloyd Middle Parker Last Parker			15. MOTHER'S MAIDEN NAME First Rose E. Middle Green Last Green								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO. 214-22-1334			17. INFORMANT Address Mrs. Catharine V. Battle, Aberdeen, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 485X Broncho pneumonia. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491X (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Const. pericarditis, Emphysema pulm.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-29, 1968 , to 1-30, 1968 , that (I) (we) last saw the deceased alive on 1-30, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Lajos I Mezei MD						DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-31-68	
22d. PHYSICIAN'S NAME (Type) Dr. Lajos I Mezei MD						22e. ADDRESS 601 South Union Ave., Havre de Grace					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2-3-68		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery			23d. LOCATION (City or Town) (County) (State) Aberdeen, Harford, Md.			
24. FUNERAL DIRECTOR Otelia D. Bullock, Havre de Grace Md.						ADDRESS 556 X Paris St.		25a. REC'D BY REGISTRAR DATE FEB 5 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jones	



35260

[Faint, illegible handwriting covering the majority of the page, likely bleed-through from the reverse side.]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00973

1. DECEASED-NAME (Type or Print) ROSS P. BENNINGTON		2a. DATE KNOWN OF ESTI- MATED <input type="checkbox"/> Unknown 19		2b. HOUR M
3. SEX M	4. RACE W	5. DATE OF BIRTH JAN. 31, 1892	6. AGE (in years last birthday) 75 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7c. BIRTHPLACE (State or foreign country) CARDIFF, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7a. BIRTHPLACE (State or foreign country) CARDIFF, Md.		9. COUNTY OF DEATH HARFORD		2c. DATE PRONOUNCED DEAD Month JAN Day 9 Year 1968
10. CITY OR TOWN OF DEATH WHITEFORD, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) BOILER FIREMAN
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY HARFORD		13c. CITY OR TOWN WHITEFORD
14. FATHER'S NAME JOHN BENNINGTON		15. MOTHER'S MAIDEN NAME PAULINE PROCTOR		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) YES		16b. SOCIAL SECURITY NO. 215-03-0411		17. INFORMANT EARL T. MYERS, DELTA, PA.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic CVDisease 4129 DUE TO, OR AS A CONSEQUENCE OF main nutrition (b) chronic alcoholism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 422.1				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>				
ACTUAL SIGNATURE Gerald P. Palmer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> B. A. H. m.		22b. DATE SIGNED 1-9-68
EXAMINER'S NAME (Type) Gerald P. Palmer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Jan. 12, 1968	23c. NAME OF CEMETERY OR CREMATORY Slate Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Delta York Co. Pa.
24. FUNERAL DIRECTOR John H. Harkins		ADDRESS Delta, Pa.		25a. REC'D BY REGISTRAR DATE JAN 12 1968
25b. REGISTRAR'S SIGNATURE Charles Judge				

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												00974	
1. DECEASED-NAME (Type or Print) MICHAEL GLEN BEST						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 1 Day 20 Year 19 68			2b. HOUR 1:25 P.M.				
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH 10-29-1967	6. AGE (In years last birthday) YRS 2 MONTHS 22 DAYS 22	IF UNDER 1 YEAR HOURS 22 MIN.		2c. DATE PRONOUNCED DEAD Month 1 Day 20 Year 19 68			2d. HOUR 1:25 P.M.				
7a. BIRTHPLACE (State or foreign country) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford			Md.				
10. CITY OR TOWN OF DEATH Aber. Prov. Grd.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kirk Army Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) N/A			12b. KIND OF BUSINESS OR INDUSTRY N/A				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 118 N. Philadelphia Blvd.			
14. FATHER'S NAME First Glen Middle R. Last Best				15. MOTHER'S MAIDEN NAME First Nancy Middle Voigt Last Voigt									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Kirk Army Hospital Records, Aber, Pr. Gd., Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTERSTITIAL PNEUMONITIS DUE TO, OR AS A CONSEQUENCE OF [SD 11] Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) SD 11												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Werner H. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 1.20.68					
EXAMINER'S NAME (Type) WERNER H. SPITZ, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
ADDRESS (Street, city, town, or county)													
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 22 Jan. 68		23c. NAME OF CEMETERY OR CREMATORY Lubbock Cemetery		23d. LOCATION (City or Town) Lubbock		(County) Texas		(State)			
24. FUNERAL DIRECTOR ADDRESS Tarring Funeral Home, Aberdeen, Md/ 21001						25a. REC'D BY REGISTRAR DATE JAN 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
LALLAH			LANGSTON			BLACKBURN		Month 1 Day 3 Year 1968 11:45 am	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Female		Caucasian		2 August 1886		81 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Pelzer, S.C.		U.S.A.				Harford			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Havre de Grace		Citizens Nursing Home		Housewife		Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Harford		Aber. Pr. Gd.				Quarters #105	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Preston B. Langston			Emma McLeroy						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			248-18-9159		Robert H. Blackburn, Same as 13 C & D				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic rheumatism.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>12/20</u> , 19 <u>67</u> , to <u>1-3</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1-3-</u> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED						
<u>I. Lajos Mezei, M.D.</u>			3 January 1968						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
I. Lajos Mezei, M.D.			Havre de Grace, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Removal		4 Jan. 1968				Spartanburg, South Carolina			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<u>Tarring Funeral Home, Aberdeen, Md. 21001</u>					DATE JAN 8 1968		<u>Charles Judge</u>		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1000. Page 5 may be retained for your files.

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00978

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00976

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- MATED	Month	Day	Year	2b. HOUR
Thomas Carl				Booth SR.		Jan	17	1968	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		2d. HOUR	
M	W	Jan 24, 1929	38 YRS.	MONTHS	DAYS	Month	Day	Year	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH				
VIRGINIA.		USA			HARFORD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
HAVERDE GRACE		US Route 40		Chauffeur		Trucking			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.		-		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2194 Duncan St	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
EARL				Booth	Catherine				MOORE.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No.				227-44-5073		Ann Sue Booth 2194 Duncan St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Fracture Skull, R femur									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
7254									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		745 1-17 1968		Auto Accident					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		n s Route 40		Howard Grace		Hav. Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Gerald C Palmer				CHIEF MEDICAL EXAMINER		Bel Air, Md.	
						ASSISTANT MEDICAL EXAMINER		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		Gerald C Palmer				DEPUTY MEDICAL EXAMINER		1-17-68	
						ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-20-68		Crest Lawn Cemetery		Howard Co, Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Philip E. Coach				1211 Chesapeake Ave.		DATE JAN 22 1968		Charles Judge	

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROCKS (RURAL)</u> c. LENGTH OF STAY IN b. <u>2 YRS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ROCKS DEER CREEK REST HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>JOPPA (RURAL)</u> d. STREET ADDRESS <u>ROUTE #1, Box 100.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WORTHINGTON LEE BOSLEY</u> First Middle Last		4. DATE OF DEATH <u>JANUARY 18 1968</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 1, 1875</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSERY</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>MILTON BOSLEY</u>	
14. MOTHER'S MAIDEN NAME <u>Amanda Treadwell</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>216-143872</u>		17. INFORMANT <u>Mrs. Nanda Lewis</u> Address <u>Kingsville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ADVANCED ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE, SENILITY</u> Conditions, if any, which gave rise to immediate cause (b) <u>1</u> (a), stating the underlying cause last. <u>4221</u> DUE TO (c) <u>1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>NONE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 1, 1966</u> to <u>JAN 18, 1968</u> that (I) (we) last saw the deceased alive on <u>JAN 16, 1968</u> and that death occurred at <u>4:00 PM</u> from the causes and on the date stated above.	22a. SIGNATURE <u>Philip W. Heuman</u> M.D.		
22b. DATE SIGNED <u>JAN 18, 1968</u>	22c. PHYSICIAN'S NAME (Type) <u>PHILIP W. HEUMAN, M.D.</u>		
22d. ADDRESS <u>307 HICKORY AVE., BELAIR, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan 20, 1968</u>	23c. NAME OF CEMETERY, OR CREMATORY <u>Mountain Christian</u>	23d. LOCATION (City, town or county) <u>Joppa Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Archer</u> ADDRESS <u>Benson, Md.</u>			
25a. RECORD BY REGISTRAR <u>JAN 22 1968</u> DATE			
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-23. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print) <u>Treaty MRS</u> <u>Brinegar</u>			2a DATE KNOWN OF DEATH Month <u>Jan</u> Day <u>27</u> Year <u>1968</u>			2b HOUR <u>19</u>				
3 SEX <u>M</u>	4 RACE <u>W</u>	5 DATE OF BIRTH <u>July 19, 1883</u>	6 AGE (in years last birthday) <u>82</u> YRS	7 UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>	8 UNDER 24 HRS HOURS <u> </u> MIN <u> </u>	2c DATE PRONOUNCED DEAD Month <u>Jan</u> Day <u>27</u> Year <u>1968</u>		2d HOUR <u> </u>		
7a BIRTHPLACE (State or foreign country) <u>North Carolina</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Hartford</u>				
10 CITY OR TOWN OF DEATH <u>STREET</u>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Trappe Road (RFD #2, Box #307)</u>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>road building</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Highway</u>		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <u>Maryland</u>			13b COUNTY <u>Hartford</u>		13c CITY OR TOWN <u>STREET</u>		13d INSIDE CITY - M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <u>RFD #2, Box #307</u>	
14 FATHER'S NAME First <u>Leroy</u> Middle <u>Mires</u> Last <u>Brinegar</u>			15 MOTHER'S MAIDEN NAME First <u>(unknown)</u> Middle <u> </u> Last <u>EVANS</u>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16b SOCIAL SECURITY NO <u>219-22-5157</u>		17 INFORMANT (See 658-6791) <u>Mr. Charles H. Brinegar</u>		ADDRESS <u>RFD #2</u> <u>Rising Sun, Maryland 21111</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic CVD disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. <u> </u> P.M. <u>19</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>1-27-68</u>				
EXAMINER'S NAME (Type) <u>Gerald E Palmer, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
			ADDRESS (Street, city, town or county)							
23a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan. 30, 1968</u>		23c NAME OF CEMETERY OR CREMATORY <u>Baptist View Cemetery</u>		23d LOCATION (City or Town) <u>Forest Hill, Hartford Co., Md.</u>		(County) (State)		
24 FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway & Williams St. Bel Air, Maryland 21014</u>				25a REC'D BY REGISTRAR <u>JAN 29 1968</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



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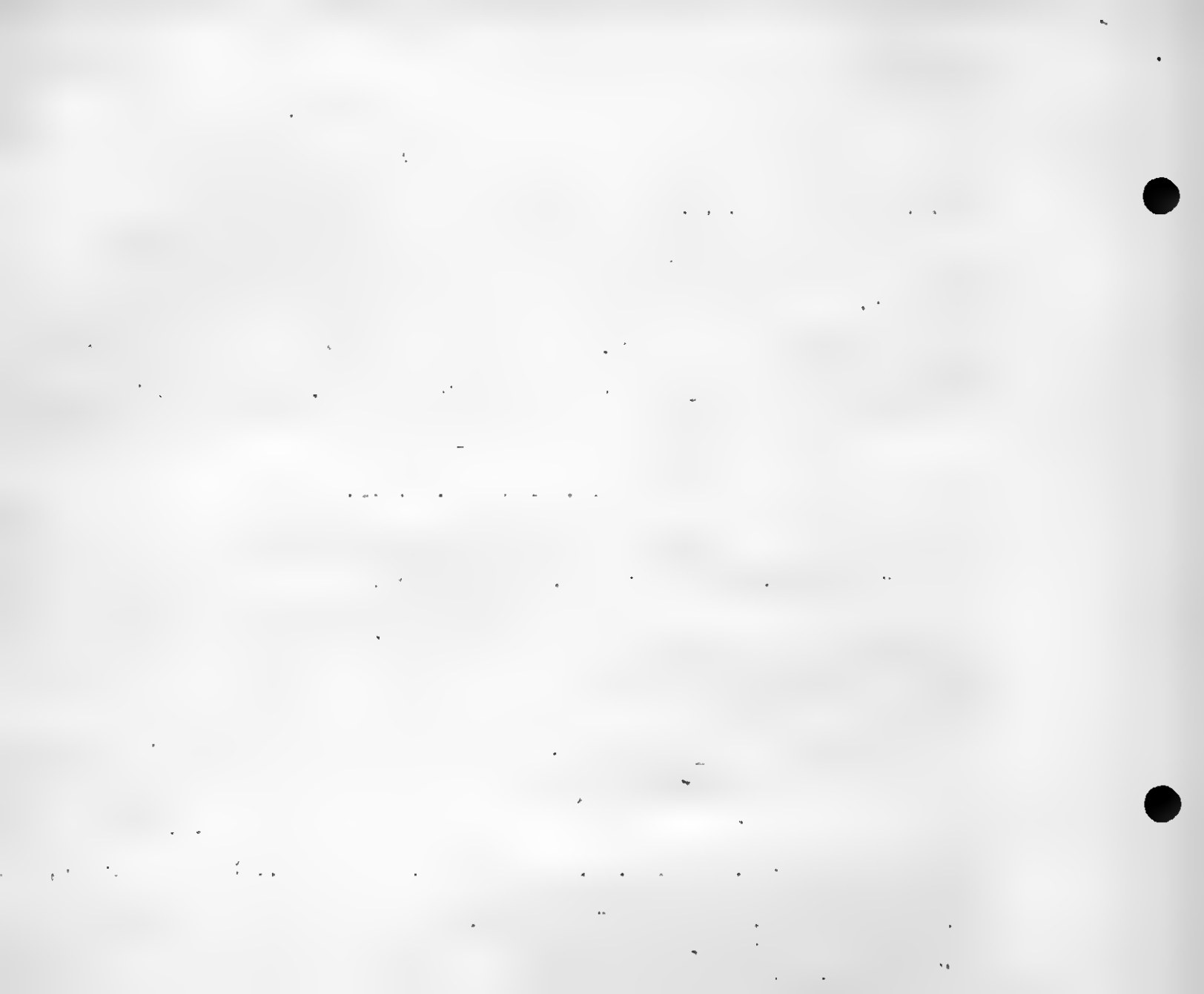
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00081

00979

1. DECEASED-NAME (Type or print) James			First Middle Last Emory Brown			2a. DATE OF DEATH Month Day Year Jan. 23 68			2b. HOUR M M								
3. SEX Male			4. RACE White			5. DATE OF BIRTH 5/19/1895			6. AGE (In years last birthday) 72 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) N.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford Md								
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Citizens Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Farm								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Harford			13c. CITY OR TOWN Churchville			13d. INSIDE CITY, LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER					
14. FATHER'S NAME Elijah			First Middle Last Brown			15. MOTHER'S MAIDEN NAME Matilda / Absher			First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 212-32-0892			17. INFORMANT Mary Hudler, R.D. 1, Aberdeen, Maryland											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4129</u> congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) <u>4211</u> due to gen. art. scl. C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) <u>4211</u> uremia												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 m					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) gangrene both feet, due to art. insufficiency																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)											
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21c. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>11-20</u> , 19 <u>67</u> , to <u>1-23</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>1-23</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) <u>view</u> the body after death.																	
22b. SIGNATURE <i>Henry H. Kwak</i>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 1-23-68								
22d. PHYSICIAN'S NAME (Type) Henry H. Kwak, M. D.			22e. ADDRESS 608 S. Union Ave., Havre de Grace, Md														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 26 Jan. 68			23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery			23d. LOCATION (City or Town) (County) (State) R.D. Bel Air, Maryland								
24. FUNERAL DIRECTOR <i>Charles Wocomb</i>			ADDRESS Tarring Funeral Home Aberdeen, Maryland			25a. REC'D BY REGISTRAR DATE JAN 29 1968			25b. REGISTRAR'S SIGNATURE <i>James J. Judge</i>								



FOR STATE
HEALTH DEPT.

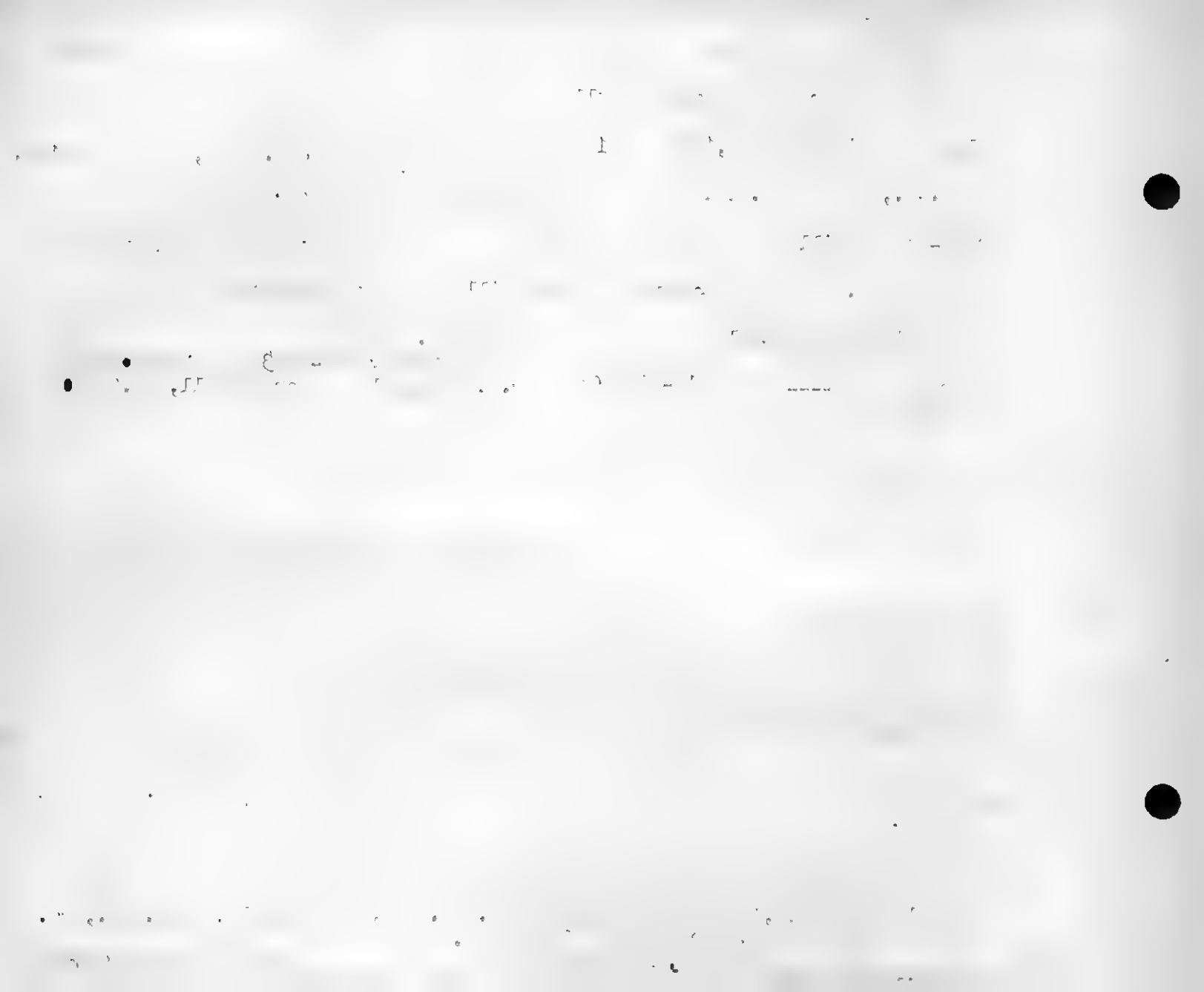
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FMS-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00980	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										00980	
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Harry Edward Bull						DATE KNOWN OF DEATH ESTIMATED			19		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD		2d HOUR	
Male	White	June 6, 1906	61					Month Day Year		11A	
7a BIRTHPLACE (State or foreign country)		7b CIT ZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Harf. Co., Md.		U.S.A.				Harford County					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR IND. STRY		
Rural-Forest Hill			Ady Road			Carpenter			Agriculture		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Md.			Harford		Forest Hill		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Ady Road		
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last							
Charles Edward Bull				Mary F. Kelly							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT (Brother) 838-7495			ADDRESS RFD #2, Box #365			
No			216-07-0705		Mr. C. Irving Bull			Forest Hill, Md. 21050			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>POISONING DUE TO C O</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8906											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
			1-1 19 68		stove became electric						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County		State
		Home			Forest Hill		Harf		Md		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Gerald C Palmer		Gerald C Palmer M.D.				B. O. A. M. D.		22b DATE SIGNED		1-2-68	
						ADDRESS (Street, city, town, or county)					
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		Jan. 4, 1968		Deer Creek Meth. Ch. Cem.		Forest Hill, Harf. Co., Md.					
24 FUNERAL DIRECTOR				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE			
W. Broadway & Williams St. Bel Air, Maryland 21014				DATE JAN 4 1968				Charles Judge			

Joseph William Foster



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) MABEL			First Middle Last HORNBARGER B URKE			2a DATE OF DEATH January 12 1968			2b HOUR 3:30 P.M.		
3 SEX Female			4 RACE White			5 DATE OF BIRTH Sept 10, 1901			6 AGE (In years last birthday) 66 YRS.		
7a BIRTHPLACE (State or foreign country) Ireland, ?			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford Md.		
10 CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 421 S. Union Ave			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) 1913 Clerk			12b KIND OF BUSINESS OR INDUSTRY U.S. Govt. Ret.		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Harford			13c CITY OR TOWN Edgewood			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last Charles Hornberger			15 MOTHER'S MAIDEN NAME First Middle Last Catherine FRASCH								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)			16b SOCIAL SECURITY NO. 220-20-7268			17. INFORMANT Alonso Rn. Havre de Grace, Md. Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovasculare accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cerebrale arteriosclerosis. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Lagos Mezci, M.D.			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED Jan. 12, 1968		
22d. PHYSICIAN'S NAME (Type) Lagos Mezci, M.D.			22e. ADDRESS Havre de Grace, Maryland								
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE Jan. 15, 1968			23c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial Cemetery			23d. LOCATION (City or Town) (County) (State) Harford Md.		
24. FUNERAL DIRECTOR Howard K. Jones			ADDRESS son, Abin don, Md.			25a REC'D BY REGISTRAR JAN 16 1968			25b. REGISTRAR'S SIGNATURE Wanda Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

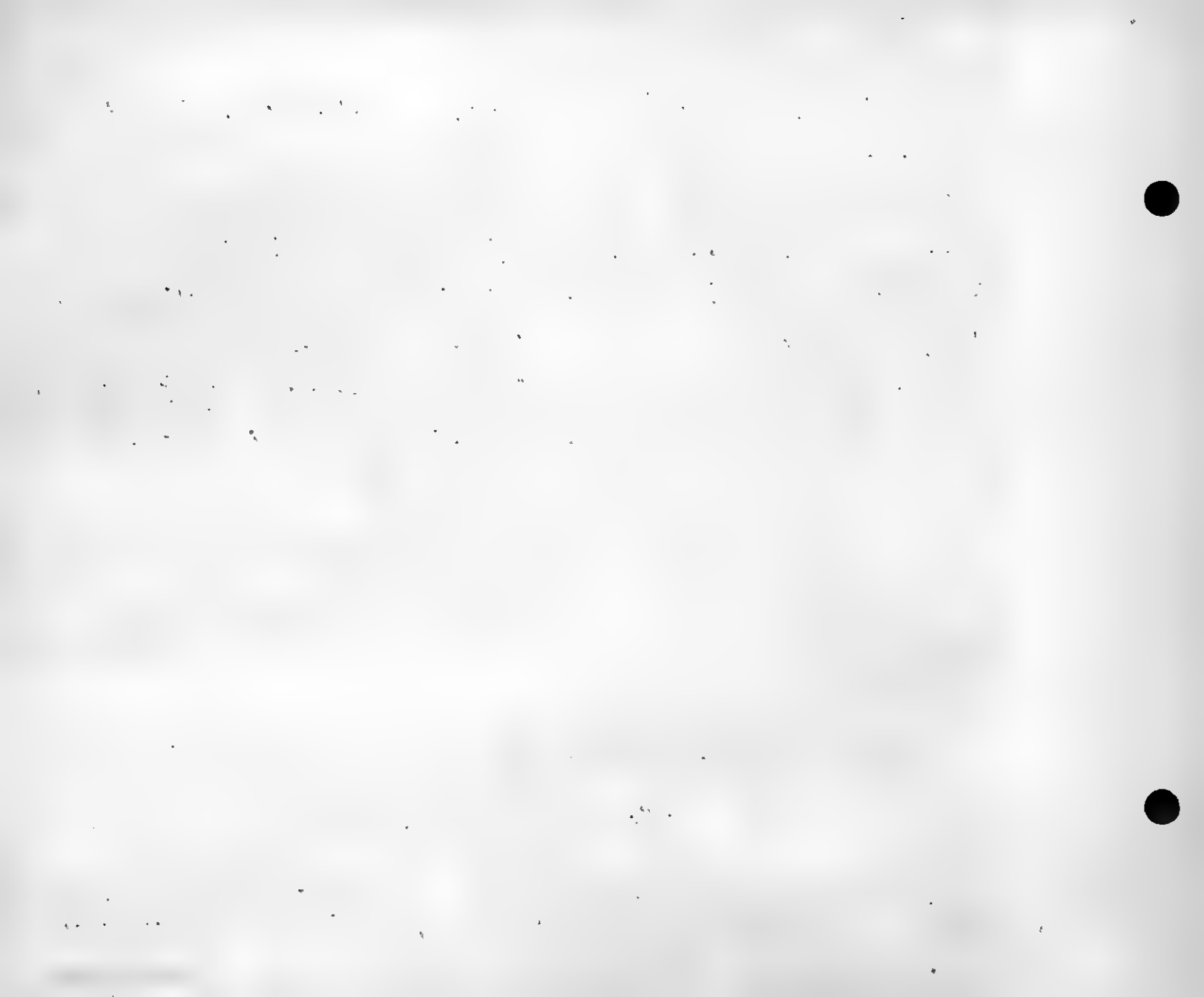
VR 115 10-1
30M REV 7/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00982

1 DECEASED-NAME (Type or print) First Middle Last Lillian M. Charsha			2a. DATE OF DEATH Month Day Year JANUARY 3 68		2b. HOUR 5:30 AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH 6/28/1902		6 AGE (In years last birthday) 65 YRS.	IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) New York	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Hartford Md.		
10. CITY OR TOWN OF DEATH Haver de Grace	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hartford Memorial Hosp.	12a USUAL OCCUPATION (Kind of work done during most of working life even if retired.) House Wife		12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before address) STATE Maryland	13b. COUNTY Hartford	13c. CITY OR TOWN Haver de Grace	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 352 Girard St	
14 FATHER'S NAME First Middle Last John Hartman		15 MOTHER'S MAIDEN NAME First Middle Last Augusta Henderson			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO Unk.	17 INFORMANT Address Delphine Hartman 316 Church St. Haver de Grace Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coron. heart failure decempen T.A.I.D. DUE TO, OR AS A CONSEQUENCE OF noted. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4-1					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 1968	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from JAN 2, 1968 to JAN 3, 1968 , that (I) (we) last saw the deceased alive on JAN 3, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE [Signature]		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
23a B. RIAL CREMATION, REMOVAL (Specify)	23b DATE 1/6/68	23c NAME OF CEMETERY OR CREMATORY Green Hill	23d LOCATION (City or Town) (County) (State) Haver de Grace Md.		
24. FUNERAL DIRECTOR [Signature]		ADDRESS Haver de Grace Md.	25a. REC'D BY REGISTRAR 2/10/74	25b. REGISTRAR'S SIGNATURE [Signature]	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
FRED			RAD			CORDUA			3 P.M.
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 12 MONTHS	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	AUG. 9 1920	47 YRS			Month Jan. Day 29, Year 1968			3 P.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			MD.
IND.		U.S.A.				Harford			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Havre De Grace			Harford Mem. Hospital			CHEMICAL ENG.			J.M. HUBER CORP.
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital give street address) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET AND NUMBER
Maryland			Harford			Havre de Grace			ROUTE 155 - STAR ROUTE
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
FRED R. CORDUA			GERTUDE ABERNATHY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS
YES			2ND WORLD WAR			LAURA M. CORDUA			STAR ROUTE HAVRE DE GRACE MD.
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease									
4129 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
f									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			HOUR A.M. P.M.		19				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held on death resulted from Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			Werner U. Spitz, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			1-30-68
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
CREMATION		FEB 3, 1968		LOO DON PARK CEM. CO.		BALTO.		MD.	
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
R. Madison Mitchell			Havre de Grace Md.			DATE 2 1968		M. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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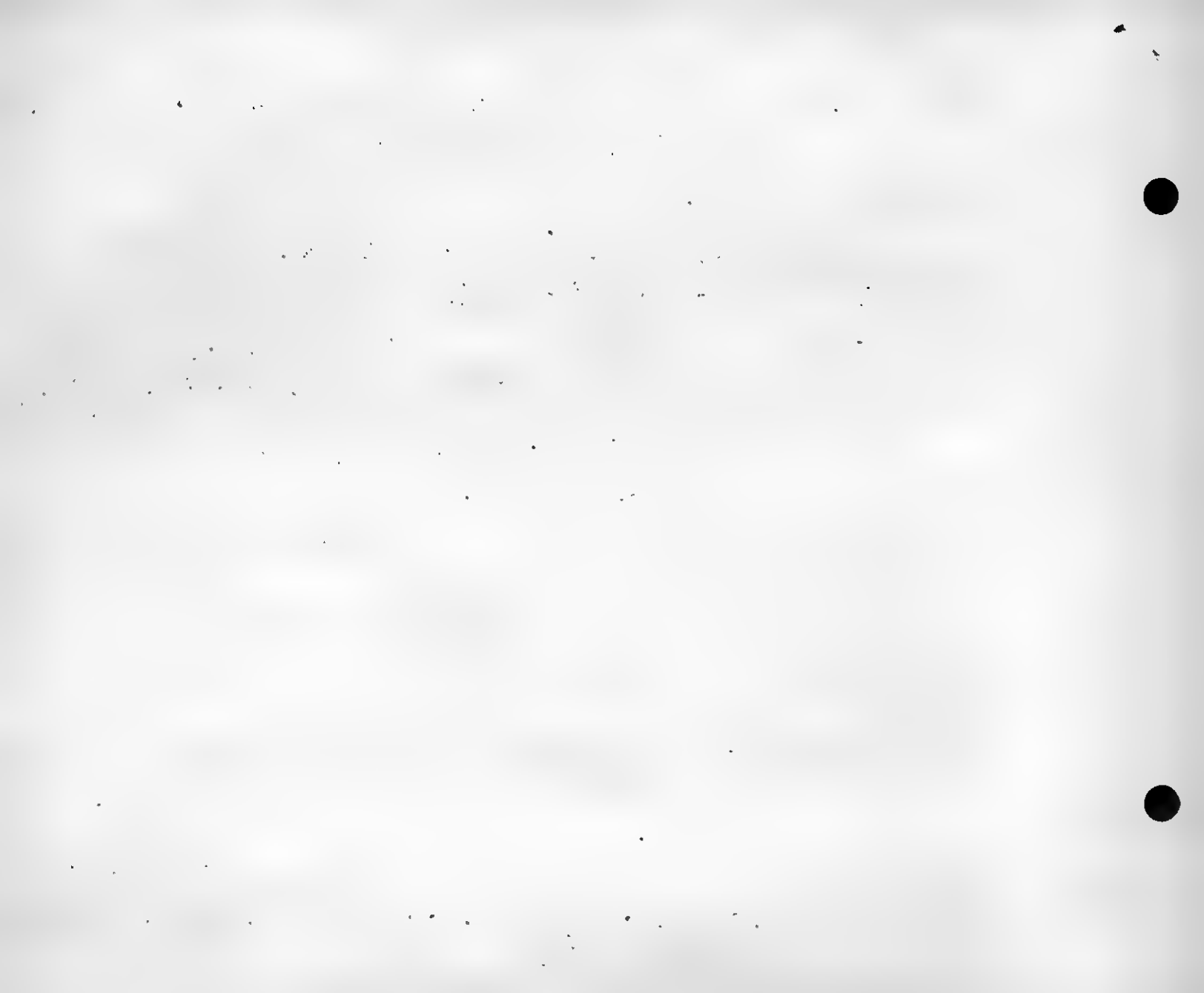
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00086

00984

1. DECEASED-NAME (Type or print) MARY		First	Middle	Last	2a. DATE OF DEATH Month JANUARY Day 24 Year 1968		2b. HOUR 10:20 AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 26 Jan. 1882		6. AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md.			
10. CITY OR TOWN OF DEATH HAVER & GRACE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD MEMORIAL HOSP		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Shoe Fab. Worker		12b. KIND OF BUSINESS OR INDUSTRY Shoe Factory			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVER & GRACE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RD 1	
14. FATHER'S NAME First William Middle Cresmer Last Cresmer		15. MOTHER'S MAIDEN NAME First Mary Middle F. Last Trago							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 220-01-4280		17. INFORMANT Address Helen Hughes, Havre de Grace, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Simple pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4.5.7									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from MAY 12, 1966 , to JAN 24, 1968 , that (I) (we) last saw the deceased alive on JAN. 24, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dudley Phillips		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/25/68					
22d. PHYSICIAN'S NAME (Type) Dudley Phillips MD		22e. ADDRESS Box 300 DARTINGTON MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 27 Jan. 1968		23c. NAME OF CEMETERY OR CREMATORY Churchville Presbyterian Cem.		23d. LOCATION (City or Town) (County) (State) Churchville, Maryland			
24. FUNERAL DIRECTOR Walter Wacambur		Tarring Funeral Home Aberdeen, Maryland		25a. REC'D BY REGISTRAR DATE JAN 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



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VR A-5(A)
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) Leo P. Davis					2a. DATE OF DEATH Month January Day 16 Year 1968				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 21 February 1905		6. AGE (In years last birthday) 62 YRS.		2b. HOUR 5:58 AM	
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md			
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Security Guard			12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 700 W. Bel Air Ave.	
14. FATHER'S NAME First John Middle Milton Last Davis (D)					15. MOTHER'S MAIDEN NAME First Mary Middle Ida Last Stanslause (D)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) Yes Oct. 40 - Nov. 40			16b. SOCIAL SECURITY NO 294-01-5548		17. INFORMANT Address Wife, same as 13 a, c & e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 410.1									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 16 1968 , to JAN 16 , 1968, that (I) (we) last saw the deceased alive on JAN 16 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John D. Yun					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/16/68		
22d. PHYSICIAN'S NAME (Type) JOHN D. YUN					22e. ADDRESS HAVRE DE GRACE, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 19 Jan. 68		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Bel Air (Harford) Maryland			
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001					25a. REC'D BY REGISTRAR DATE JAN 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH
LULA			ALICE		DAVIS		N		Month Jan. Day 31 Year 1968 1:00 am
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		Caucasian		24 May 1878			89 YRS		IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Virginia		U.S.A				Harford Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Aberdeen			Route #1			Housewife		Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Harford		Aberdeen		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route #1, Box 125
14. FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME
George			Miller (D)		Mary		McCormick (D)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17 INFORMANT Address				
No			227-22-4783 F-2		Leota Call, RD. 1, Aberdeen, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypokinetic Pneumonia									2 days
200.9 DUE TO, OR AS A CONSEQUENCE OF									Days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) Intermittent-sclerotic CVD Disease									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Diabetes Mellitus									Entire life
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
110X Rt. Hemiplegia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from Oct 1928, to Jan 1968, that (I) (we) lost the deceased alive on Jan 21 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE						DEGREE		22c. DATE SIGNED	
Ralph Horky						MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		31 January 1968	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
G. Ralph Horky, M.D.						Churchville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Removal		1 Feb. 1968		Fall Hill Cemetery		Saltville Virginia			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Tarring Funeral Home, Aberdeen, Maryland				DATE Feb 2 1968		James J. Jones			



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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR			
First		Middle		Last		Month		Day		Year		
Alice		Roberta		Dayhoof		Jan.		17		68		
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		FUNERAL 1 YEAR		FUNERAL 24 HRS.	
F		W		1-7-1890			78 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Md.		U.S.A.				Harford Md						
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Havre de Grace				Citizens Nursing Home				Housewife		Homemaker		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.				Harford		Bel Air		YES		Route 2, Box 282		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME								
First		Middle		Last		First		Middle		Last		
James		Preston		Beale		Susan Jane		Wilgis				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No				16b. SOCIAL SECURITY NO.		17. INFORMANT (Husband) 838-3624		Address RFD # 2, Box # 282 Bel Air, Md. 21014				
				218-32-0966		Mr. John T. Dayhoof, Sr.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac Failure</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardio-Vascular</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Disease. secondary Cerebral Vascular</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
43												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
				HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No		City or Town		
										County		
										State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 9</u> , 19 <u>68</u> , to <u>Jan 17</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Jan 17</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE				DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
<u>Ralph H. H. H.</u>										1/17/68		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)				
Burial		January 19, 1968		Mt. Zion Methodist Church Cem.				Bel Air, Harford Co., Md. 21014				
24. FUNERAL DIRECTOR												
Joseph William Foster				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
				W. Broadway & Williams St. Bel Air, Maryland 21014				JAN 19 1968		Charles Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR	
Henry Dentry				August		Dentry		Month Day Year Jan. 30 1968		M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD		2d HOUR
M	W	May 20, 1895		72 YRS					Month Day Year Jan 30 1968		M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				Md	
Baltimore, Maryland		U.S.A.				Hartford					
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bel Air				5 Lake Fanny Road				Horse Stables		Livestock	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland				Hartford		Bel Air		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5 Lake Fanny Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last Charles G Dentry			First Middle Last Henrietta Dames								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17 INFORMANT (Wife)		ADDRESS			
Yes				WW*1 and #2		218-32-0621		Mrs. Elsie - Catherine Dentry		5 Lake Fanny Road Bel Air, Maryland 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Sclerosis 341X DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Gerald C Palmer				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				1-30-68			
EXAMINER'S NAME (Type) Gerald C Palmer MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Bel Air Md.			
ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Feb 2, 1968		Parkwood Cemetery		Baltimore, Baltimore Co., Maryland					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Joseph William Foster				W. Broadway & Williams St. Bel Air, Maryland 21014				FEB 1 1968			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A155(4)
30M REV. 12-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) Bessie A. EVANS						2a. DATE OF DEATH Month January Day 21 Year 1968			2b. HOUR 3:30 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 10 - 1885		6. AGE (In years last birthday) 82 YRS.		F UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) England		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Harford Md.					
10 CITY OR TOWN OF DEATH Harre de Grace		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Harford Mem. Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY Housewife		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Harre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 735 Otsego St.			
14 FATHER'S NAME First ? Middle ? Last ?				15 MOTHER'S MAIDEN NAME First ? Middle ? Last ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give year or dates at service)				16b. SOCIAL SECURITY NO. unk		17 INFORMANT Edward Evans 335 Otsego St. Harre de Grace Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4110 Uremia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Arteriosclerotic Cardio-vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) renal disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 dg	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 442X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 1-17 , 19 68 , to 1-24 , 19 68 , that (I) (we) last saw the deceased alive on 1-24 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Wm. H. Wadsworth DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 1/27/68					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/26/68		23c. NAME OF CEMETERY, OR CREMATORY Fangel Hill		23d. LOCATION (City or Town) Harre de Grace, Md (County) (State)					
24. FUNERAL DIRECTOR Levinson, Jm. Harre de Grace, Md ADDRESS						25a. REC'D BY REGISTRAR JAN 26 1968		25b. REGISTRAR'S SIGNATURE Judge			

349. 42. 1111. 1111.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

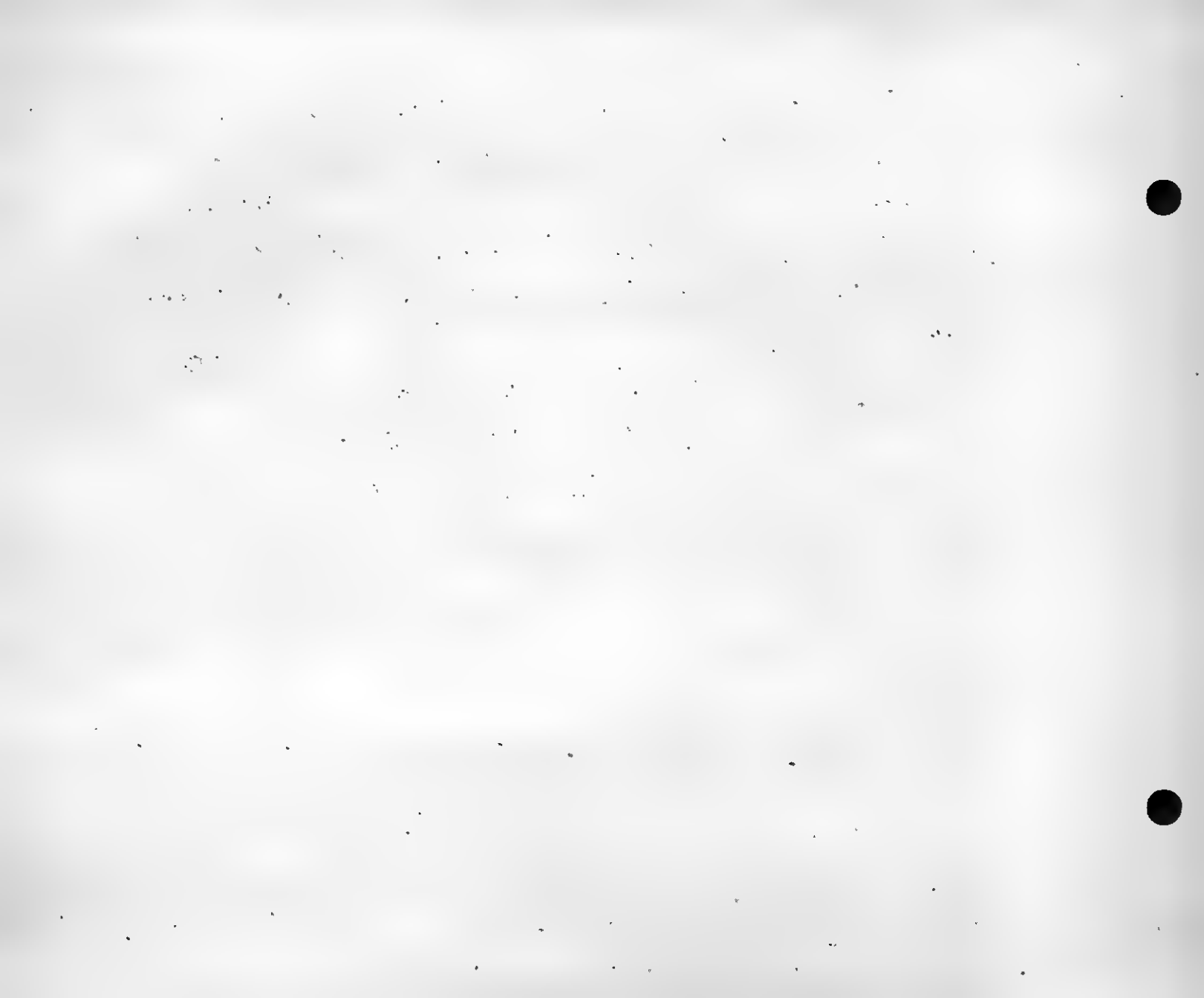
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00992

CERTIFICATE OF DEATH

00990

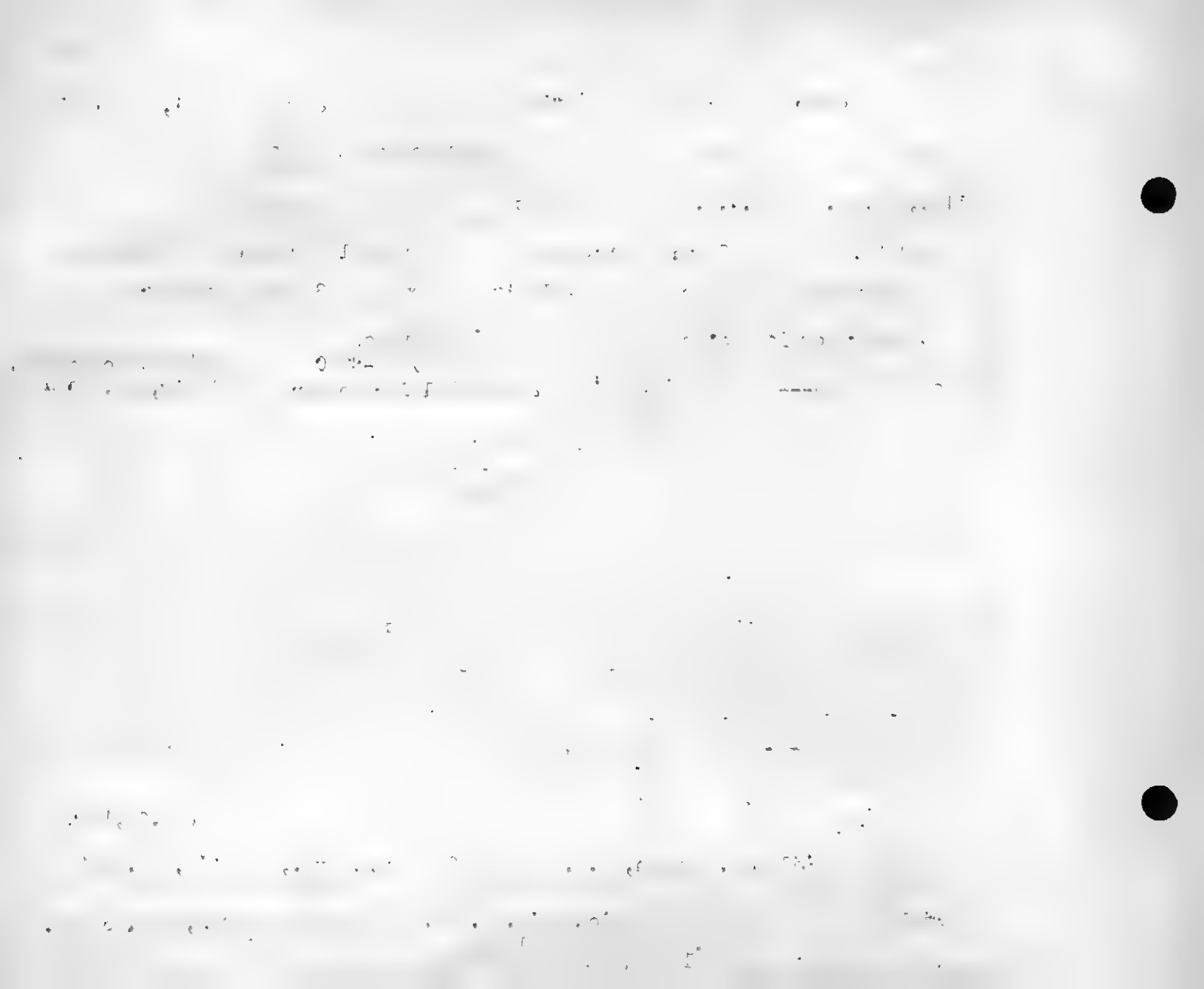
1 DECEASED-NAME (Type or print) DANIEL CLEVELAND EVANS			2a DATE OF DEATH Month JANUARY Day 20 Year 68			2b HOUR 10⁵⁰ A.M.	
3. SEX MALE		4. RACE WHITE		5 DATE OF BIRTH Aug. 25. 1885		6. AGE (In years last birthday) 82 YRS.	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD	
10. CITY OR TOWN OF DEATH HARFORD		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD MEMORIAL HOSP		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b. COUNTY HARFORD		13c. CITY OR TOWN HARFORD		13d. NO. OF DAY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last Wm. Evans		15. MOTHER'S MAIDEN NAME First Middle Last ?		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. Und.		17 INFORMANT Edward Evans 735 Chicago St Harford Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thromboses 4-20-68 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1-2 , 19 68 , to 1-20 , 19 68 , that (I) (we) lost the deceased alive on 1-30 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles W. Loman				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/23/68		23c. NAME OF CEMETERY OR CREMATORY Angel Hill		23d. LOCATION (City or Town) (County) (State) Harford Harford Md	
24. FUNERAL DIRECTOR William R. Harford				25a. REC'D BY REGISTRAR JAN 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First	Middle	Lost	2a DATE OF DEATH Month Day Year		2b HOUR			
Joseph Turner Foster						January 21, 1968		7A. M.			
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS			
Male		White		April 20, 1894		73 YRS					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Phila., Penna.		U.S.A.				Harford Md.					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Bel Air			35 West Broadway			Funeral Director		Mortician			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Maryland			Harford		Bel Air		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		35 West Broadway		
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
William Norris Foster						Emma Turner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO. (If you give war or dates of service)			17 INFORMANT (Son) 838-4040		Address 48 W. Gordon St.			
No			218-32-1917			Joseph William Foster		Bel Air, Md. 21014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE FAILURE DUE TO ARTERIO- DUE TO, OR AS A CONSEQUENCE OF SCLEROTIC CARDIOVASCULAR Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 42+1 (b) DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)										OVER 19 YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
NONE					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
FOR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (if either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work											
22a. I certify that (I) (this hospital) attended the deceased from 1958, 19 to JAN 21, 1968, that (I) (we) last saw the deceased alive on JAN 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE					22c. DATE SIGNED						
Philip W. Heuman, M.D.					Jan. 21, 1968						
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS						
Philip W. Heuman, M.D.					307 Hickory Ave., Bel Air, Md. 21014						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Jan. 23, 1968		Mt. Zion Meth. Ch. Cem.		Fountain Green, Harf. Co., Md.					
24. FUNERAL DIRECTOR		W. Broadway & Williams		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Joseph William Foster		Bel Air, Maryland 21014		DATE JAN 24 1968		J. C. Judge					

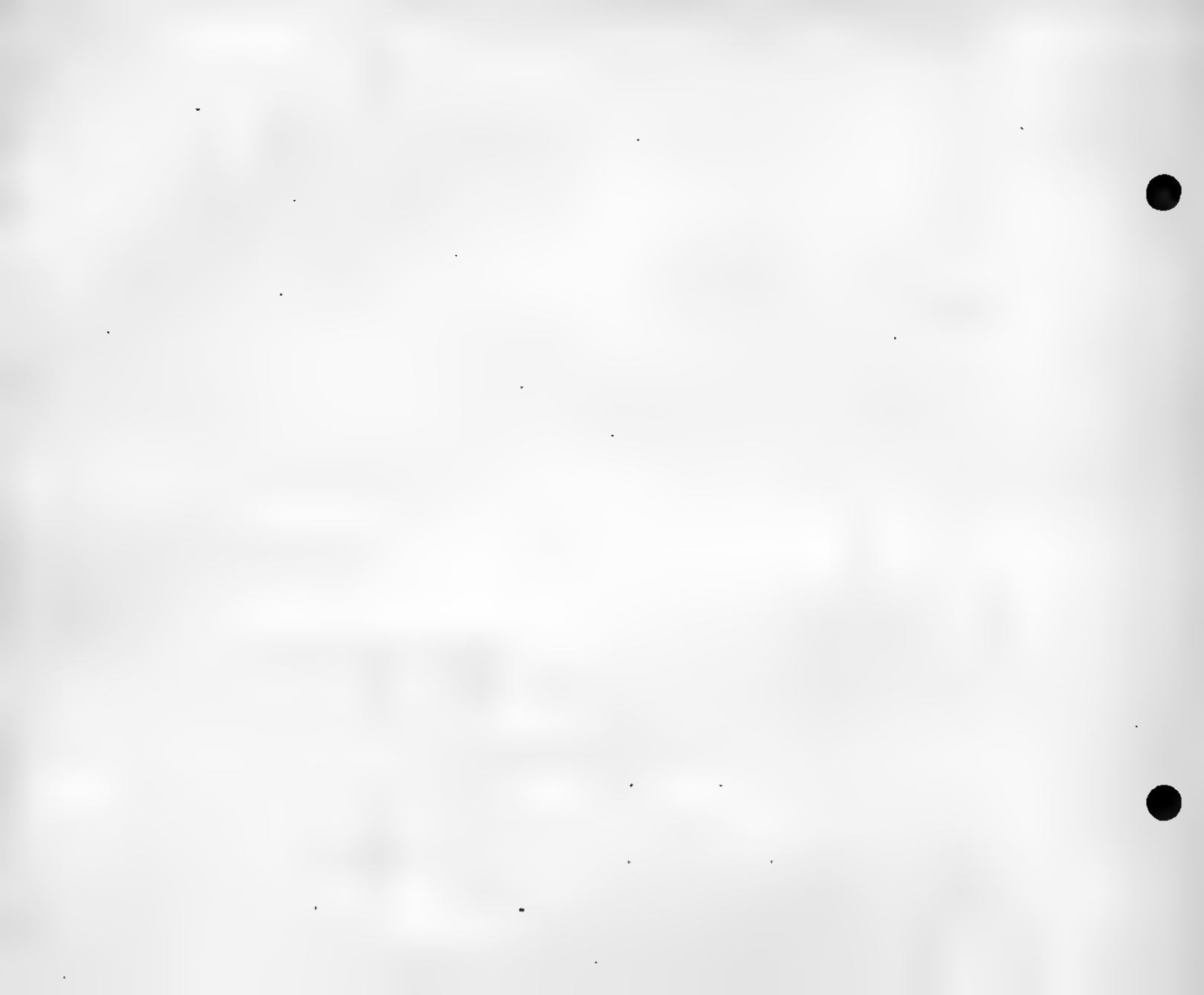


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form "Page 5 may be retained for your files."

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00992

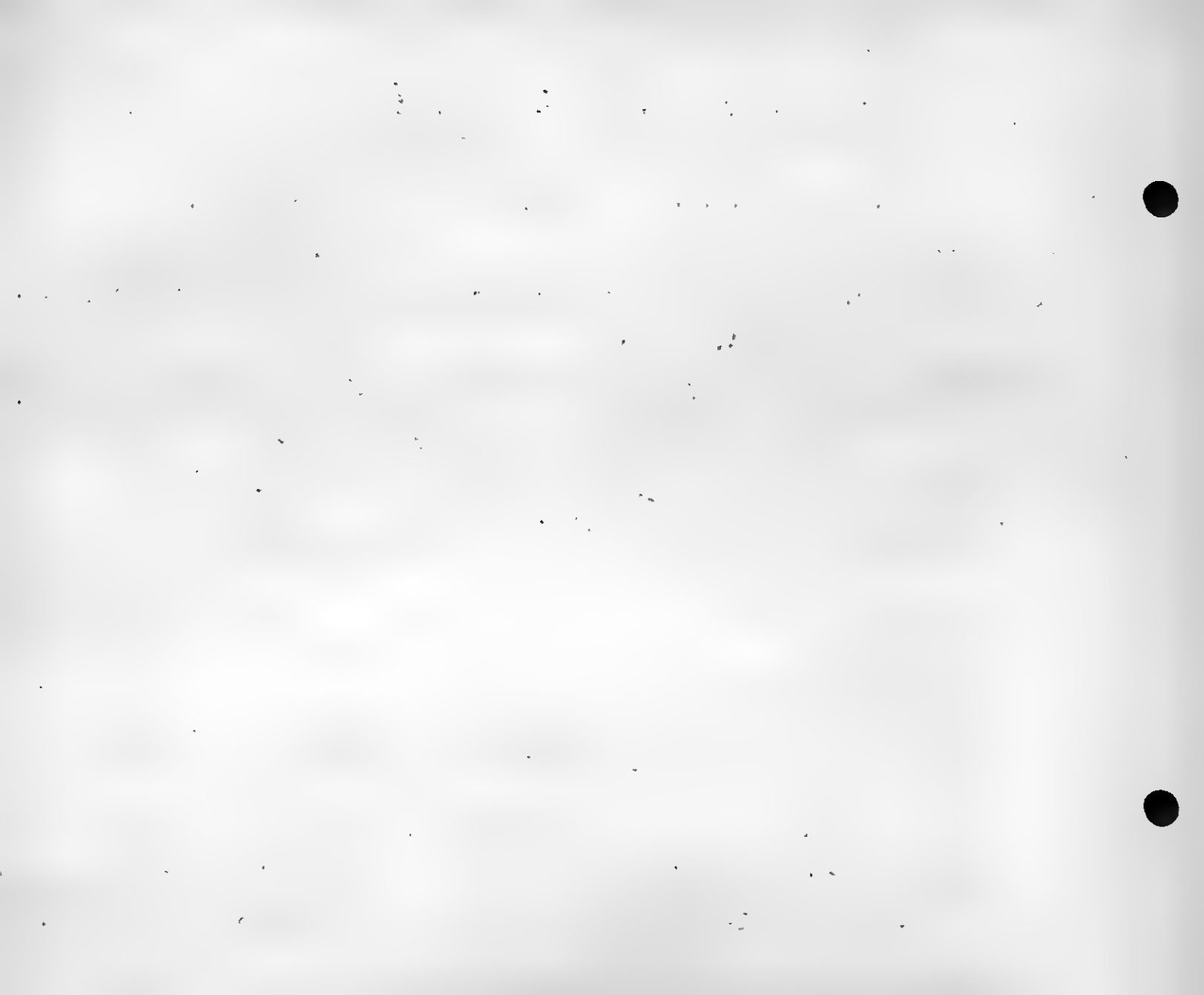
1 DECEASED-NAME (Type or Print)		First Middle Last		DAVID -- () GLENN		2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year		2b HOUR	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7c DATE PRONOUNCED DEAD	
Male		White		July 7, 1967		66 6		January 9, 1968	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		2d HOUR	
Baltimore, Md		USA				Harford		9:00	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USJA: OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Edgewood		Harford Memorial Hospital		none		none			
13a USJA: RESIDENCE (Where deceased lived, if institution- Residence before)		13b CITY OR TOWN		3a INSIDE CITY LIMITS?		13c STREET AND NUMBER			
Maryland		Harford		Edgewood		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2018 Starr Street	
14 FATHER'S NAME		First Middle Last		15 MOTHER'S MAIDEN NAME		First Middle Last			
Unknown				Patricia		-- Gilbert			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no		none		rs. Gloria roun (Case worker)		Co. Harford			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial Pneumonitis</u> <u>484X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>492:</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Werner U. Spitz</u>		EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
				ADDRESS (Street, city, town, or county)		22b DATE SIGNED		1/9/68	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		Jan. 10, 1968		Harford Memorial Gardens		Harford, Md. Harford			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Howard K. McComas & Son, Abingdon, Md. 21002				JAN 11 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>Marjorie R. Griffith</i>					2a. DATE OF DEATH Month <i>1</i> Day <i>15</i> Year <i>68</i>			2b. HOUR M <i>6</i>			
3. SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>1-5-1889</i>			6. AGE (In years last birthday) <i>79</i> YRS.		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> M.N.		
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Harford Co.</i>					
10. CITY OR TOWN OF DEATH <i>Madonna</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Homemaker</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Homemaker</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Baltimore</i>			13c. CITY OR TOWN <i>Towson</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>217 Rodgers Forge Rd.</i>	
14. FATHER'S NAME First <i>George</i> Middle <i>A.</i> Last <i>Davis</i>					15. MOTHER'S MAIDEN NAME First <i>Fannie</i> Middle <i>Gould</i> Last <i>Gould</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>215 07 8835</i>		17. INFORMANT Address <i>Marjorie Griffith 217 Rodgers Forge Rd.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arterio Sclerotic C - u Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Senility</i> Conditions if only, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <i>4201</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>1</i> Day <i>15</i> Year <i>68</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 15, 1968</i> , to <i>Jan 15, 1968</i> , that (I) (we) last saw the deceased alive on <i>Jan 15, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>W. Paul Byerly</i>				DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1/16/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Dr. W. Paul Byerly</i>				22e. ADDRESS <i>5820 York Road</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1/17/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>			23d. LOCATION (City or Town) (County) (State) <i>Baltimore Md.</i>				
24. FUNERAL DIRECTOR <i>Mitchell-Wiedefeld Home</i>				ADDRESS <i>6500 York Rd</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 23 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>			



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VRAYS 1/68
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
CERTIFICATE OF DEATH																			
00994																			
1. DECEASED NAME (Type or print)			First Luella			Middle May			Last Gross			2a. DATE OF DEATH Month 1 Day 13 Year 68			2b. HOUR 5:20A				
3. SEX Female			4. RACE White			5. DATE OF BIRTH 8/12/1887			6. AGE (in years last birthday) 80 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN				
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford										
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Citizen Nursing H.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home										
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN White Hall			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Jarrettville Pike							
14. FATHER'S NAME First Lewis			Middle Troyer			Last Gennie			15. MOTHER'S MAIDEN NAME First Melvin			Middle Melvin			Last Melvin				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 212-40-7933			17. INFORMANT Mrs. Charlotte Ward			Address White Hall, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Cardiac Decompensation 2 months 4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4.2.21 (b) A.S. Cl. D. Class IV DUE TO, OR AS A CONSEQUENCE OF (c) 3-4 yrs.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Senility																			
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) —													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) —			21f. LOCATION Street or R.F.D. No. City or Town County State —													
22a. I certify that (I) (this hospital) attended the deceased from Dec. 16, 1967 , to Jan. 13, 1968 , that (I) (we) last saw the deceased alive on Jan. 13th, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Edward C. Loo, M.D.					22c. DATE SIGNED 1/13/68				
22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.			22e. ADDRESS Havre de Grace, Md.			22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 1/16/1968			23c. NAME OF CEMETERY OR CREMATORY Bethel			23d. LOCATION (City or Town) (County) (State) Madonna, Harford, Md.										
24. FUNERAL DIRECTOR Charles E. Kurtz			ADDRESS Jarrettville, Md.			25a. REC'D BY REGISTRAR DATE JAN 17 1968			25b. REGISTRAR'S SIGNATURE J. Charles Jones										

21084



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VR 4-15 (4)
30M REV 7/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00995

1 DECEASED-NAME (Type or print) William Frederick Gunkel			2a. DATE OF DEATH Month January Day 16 Year 1968			2b. HOUR 2:40 AM			
3 SEX Male		4. RACE White		5. DATE OF BIRTH NOV. 28-1928		6. AGE (In years last birthday) 39 YRS		IF UNDER YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Hartford Md.			
10 CITY OR TOWN OF DEATH Harre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hartford Memorial Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY ELECTRONICS			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD		13b. COUNTY Hartford		13c. CITY OR TOWN Harre de Grace		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Box 124 B RD 1	
14. FATHER'S NAME First WILLIAM Middle F. Last GUNKEL			15. MOTHER'S MAIDEN NAME First THERESA Middle B. Last GUNKEL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. 197-1956		17. INFORMANT Mrs ELIZABETH HACEERTY 2907 DUNLOW		Address			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarctus 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from JAN 6, 1968 , to JAN 16, 1968 , that (I) (we) last saw the deceased alive on JAN 16, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John D. Yun		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/16/68			
22d. PHYSICIAN'S NAME (Type) JOHN D. YUN		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JAN 19, 1968		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE MD			
24. FUNERAL DIRECTOR VLURICH FUNERAL HOME-DUNDALK MD		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00996

1 DECEASED-NAME (Type or print) <i>Joseph J. Hlatem</i>			2a. DATE OF DEATH Month <i>1</i> Day <i>4</i> Year <i>68</i>			2b. HOUR <i>1:12</i> M	
3 SEX <i>M</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>2/3/1900</i>		6 AGE (In years last birthday) <i>67</i> YRS.	
7a BIRTHPLACE (State or foreign country) <i>Philadelphia, U.S.A.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Harford</i> Md.	
10 CITY OR TOWN OF DEATH <i>Haure de Grace</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Haure de Grace</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <i>600 Franklin St</i>		14. FATHER'S NAME First <i>Thomas M.</i> Middle <i>Hlatem</i> Last <i>Hlatem</i>		15 MOTHER'S MAIDEN NAME First <i>—</i> Middle <i>—</i> Last <i>—</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)	
16b SOCIAL SECURITY NO. <i>Unk</i>		17. INFORMANT <i>Thomas Hlatem</i>		18. ADDRESS <i>Bel Air, Md.</i>		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>	
1B CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>coronary thrombosis</i>							
410.9 DUE TO, OR AS A CONSEQUENCE OF							
(b) <i>Coronary insufficiency</i>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <i>aseptic</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>January</i> , 19 <i>62</i> , to <i>1-4</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>1-4</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Edward J. Simon</i>		DEGREE <i>EDWARD J. SIMON</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>1-4-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>EDWARD J. SIMON</i>		22e. ADDRESS <i>HAURE DE GRACE, M.D.</i>		23a. BURIAL, CREMATION, REMOVAL (Specify)			
23b. DATE <i>1/8/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Erin</i>		23d. LOCATION (City or Town) (County) (State) <i>Haure de Grace Md.</i>		24. FUNERAL DIRECTOR <i>Barry H. Hlatem</i>	
25a. REC'D BY REGISTRAR DATE <i>JAN 8 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>					



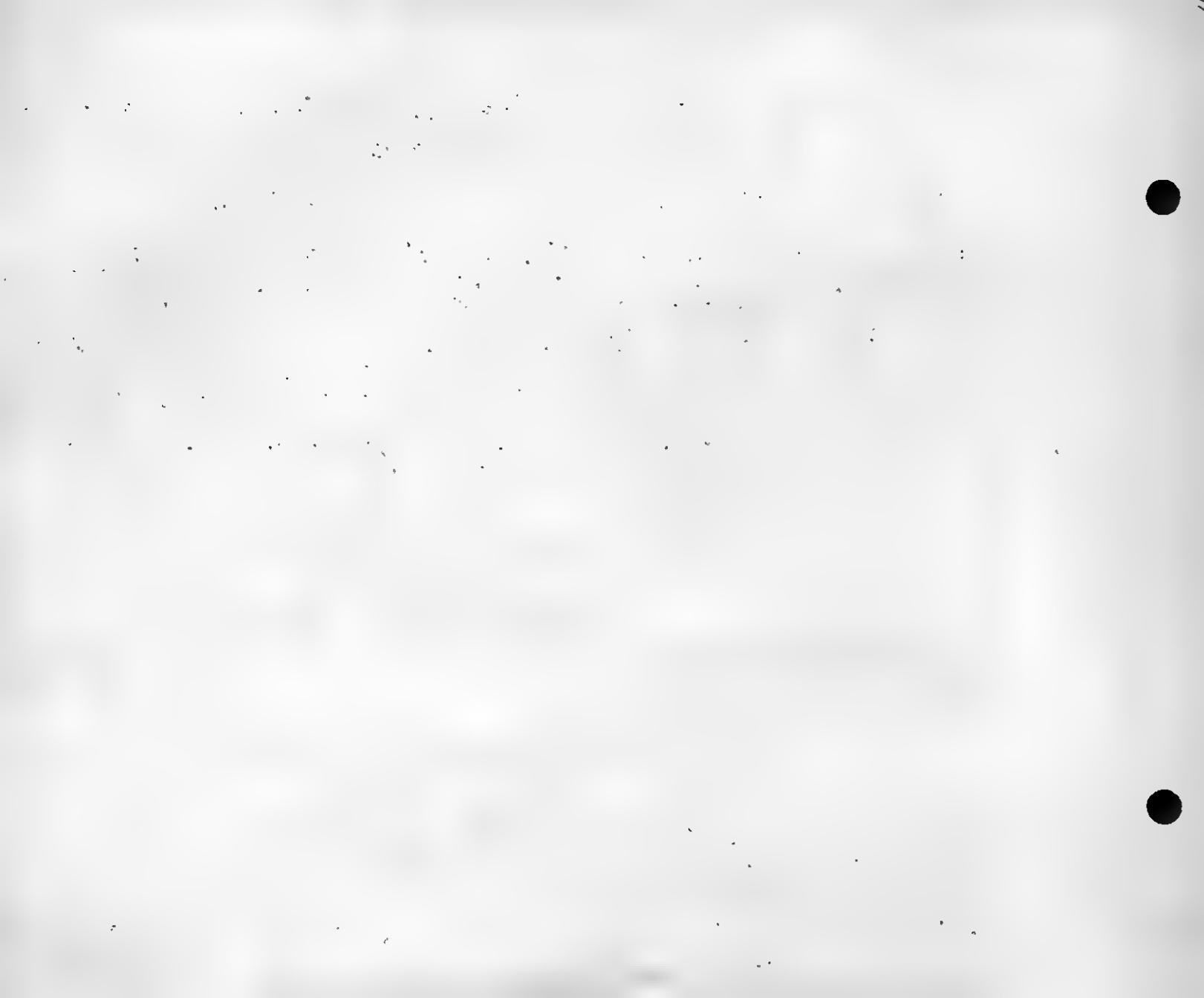
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CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Edwin STANTON			2a. DATE OF DEATH Month JAN Day 25 Year 1968			2b. HOUR 2:20 AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>	
3. SEX male		4. RACE white		5. DATE OF BIRTH AUG. 12, 1901		6. AGE (In years last birthday) 66 YRS.	
7a. BIRTHPLACE (State or foreign country) PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md.	
10. CITY OR TOWN OF DEATH HAVERDE GRACE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MANUFACTURER		12b. KIND OF BUSINESS OR INDUSTRY TOBACCO	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE PENNA		13b. COUNTY HARFORD		13c. CITY OR TOWN HARRISBURG		13d. INSIDE CITY (Y.N.T.S?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME EDWIN STANTON		15. MOTHER'S MAIDEN NAME ALMEDA WANLOWER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO 168-36-7188		17. INFORMANT MRS. LAWRAISON SAYRE ABERDEEN, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Extensive anterior myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 4221							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hours 10 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) C.V.A. - Thrombosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 20, 1967 , to Jan 25, 1968 , that (I) (we) last saw the deceased alive on JAN 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edward C. Loo, M.D.		DEGREE EDWARD C. LOO, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/25/68	
22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22e. ADDRESS HAVERDE GRACE, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE JAN. 27, 1968		23c. NAME OF CEMETERY OR CREMATORY Harrisburg Cemetery		23d. LOCATION (City or Town) (County) (State) Harrisburg, PENNA.	
24. FUNERAL DIRECTOR Joseph William Foster		ADDRESS W. Broadway & Williams Del Air Maryland 21014		25a. REC'D BY REGISTRAR DATE JAN 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



91000

CERTIFICATE OF DEATH

00998

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hayre de Grace</u>				c. LENGTH OF STAY in 1b <u>11/1/67 to 1/9/68</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home</u>				d. STREET ADDRESS <u>1006 S. Adams St.</u>			
3 NAME OF DECEASED (Type or print) First <u>Pauline</u> Middle <u>J.</u> Last <u>Hillman</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>9</u> Year <u>19 68</u>			
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>4-12-1879</u>		9 AGE (In years last birthday) <u>88</u> yrs	IF UNDER 1 YEAR Months <u>9</u> Days <u>19</u> Hours <u>68</u> Min	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Portsmouth, Va.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-50-7091</u>		17 INFORMANT <u>Joel Hecht</u> Address <u>1006 S. Adams St. Hayre de Grace Md. 21078</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4100</u> DUE TO <u>Coronary Dissection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Dissection</u> DUE TO <u>15 years</u> (c) <u>Hypertensive Cor. Dis. and B. em.</u> DUE TO <u>15 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 1, 1967</u> , to <u>January 9, 1968</u> ; that (I) (we) last saw the deceased alive on <u>January 9, 1968</u> , and that death occurred at <u>12:05 P.M.</u> from causes and on the date stated above							
22a. SIGNATURE <u>Edward J. Simon</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-9-68</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD J. SIMON</u>				22d. ADDRESS <u>HAYRE DE GRACE, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>1/9/1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew</u>		23d. LOCATION (City or Town) (County) (State) <u>Norfolk, Va</u>	
24 FUNERAL DIRECTOR <u>Gerrington Son Hayre de Grace Md</u>				25a REC'D BY REGISTRAR DATE <u>JAN 11 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
LEE			A DRE			HONEYCUTT		1/23 1968 UNK M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year	
male	white	Sept. 24, 1913	54 YRS					January 23, 1968 A:35 M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
North Carolina		SA				Harford Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Edgewood			Harford Memorial Hospital			Maintenance Worker		Auto-Sales	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland				Harford		Joppa, Md.		13e. STREET AND NUMBER 1008 Trimble Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
John Lester Honeycutt			Dulice			-- Honeycutt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT				
Yes			441-07-3454		Mrs. Katherine Honeycutt, 1008 Trimble Road				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Spontaneous Intracerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			Werner Spitz, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 1/23/68	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan. 24, 1968		Sunerset Funeral Home		Salisbury N.C.			
24. FUNERAL DIRECTOR				ADDRESS		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Howard W. McComas & Son, Abingdon, Md. 21009						DATE JAN 25 1968		Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01002

CERTIFICATE OF DEATH

01000

1 DECEASED-NAME (Type or print) <i>Johns W. son</i>			First	Middle	Last	2a. DATE OF DEATH Month <i>JAN</i> Day <i>10</i> Year <i>1968</i>			2b. HOUR <i>12</i> M		
3. SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>SEPT. 10, 1897</i>		6 AGE (In years last birthday) <i>70</i> YRS.		7 UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Harford</i>					
10. CITY OR TOWN OF DEATH <i>Chesapeake</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>FARM OWNER</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>U.S.A.</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>				13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Darlington</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Box 12 R.R. 1</i>	
14. FATHER'S NAME <i>Johns W. Hopkins</i>			First	Middle	Last	15. MOTHER'S MAIDEN NAME <i>JANE EDGE</i>			First	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>219-10-7109</i>			17. INFORMANT <i>Mrs. Johns W. Hopkins</i>			Address <i>Box 12 R.D. 1 Darlington</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> <i>410.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Pneumonia, chest & Gen'l</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 MIN</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1/6</i> , 1968, to <i>1/10</i> , 1968, that (I) (we) last saw the deceased alive on <i>1/10</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <i>9:42 AM</i>											
22b. SIGNATURE <i>Dudley Phillips</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1/10/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Dudley Phillips MD</i>		22e. ADDRESS <i>Darlington Md 21834</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Jan. 13, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Darlington Cemetery</i>		23d. LOCATION (City or Town) <i>Darlington</i>		(County) <i>Harford</i>		(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>John H. Harbins</i>		ADDRESS <i>Delta, Pa.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 16 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR		
DELBERT ALFRED HOUCK						Month Day Year		M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD		
male	white	16 Nov. 1910	57 YRS					Month Day Year		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		11 HOUR		
North Carolina		U.S.A.				Harford		11:00 A M		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Aberdeen			office of Gerald C. Palmer			Carpenter		Construction		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Harford		Aberdeen				RFD 2, Box 313 --B	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Seaver			Houck			Mary Walters				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS				
no			217-13-9513			Ruth H. Childers, Aberdeen, Maryland				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Acute Alcoholic Intoxication</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Acute Alcoholic Intoxication										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)				
UNK P.M. 1/22 1968						drowned while intoxicated				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or RFD No City or Town County State				
water						Aberdeen, Harford, Md.				
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
22b DATE SIGNED			1/23/68							
22c ADDRESS (Street, city, town, or county)										
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial			25 Jan. 68		Harford Memorial Gardens		Aberdeen, Maryland			
24 FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE				
Tarring Funeral Home Aberdeen, Maryland			DATE JAN 26 1968			Charles Judge				

MEDICAL CERTIFICATION



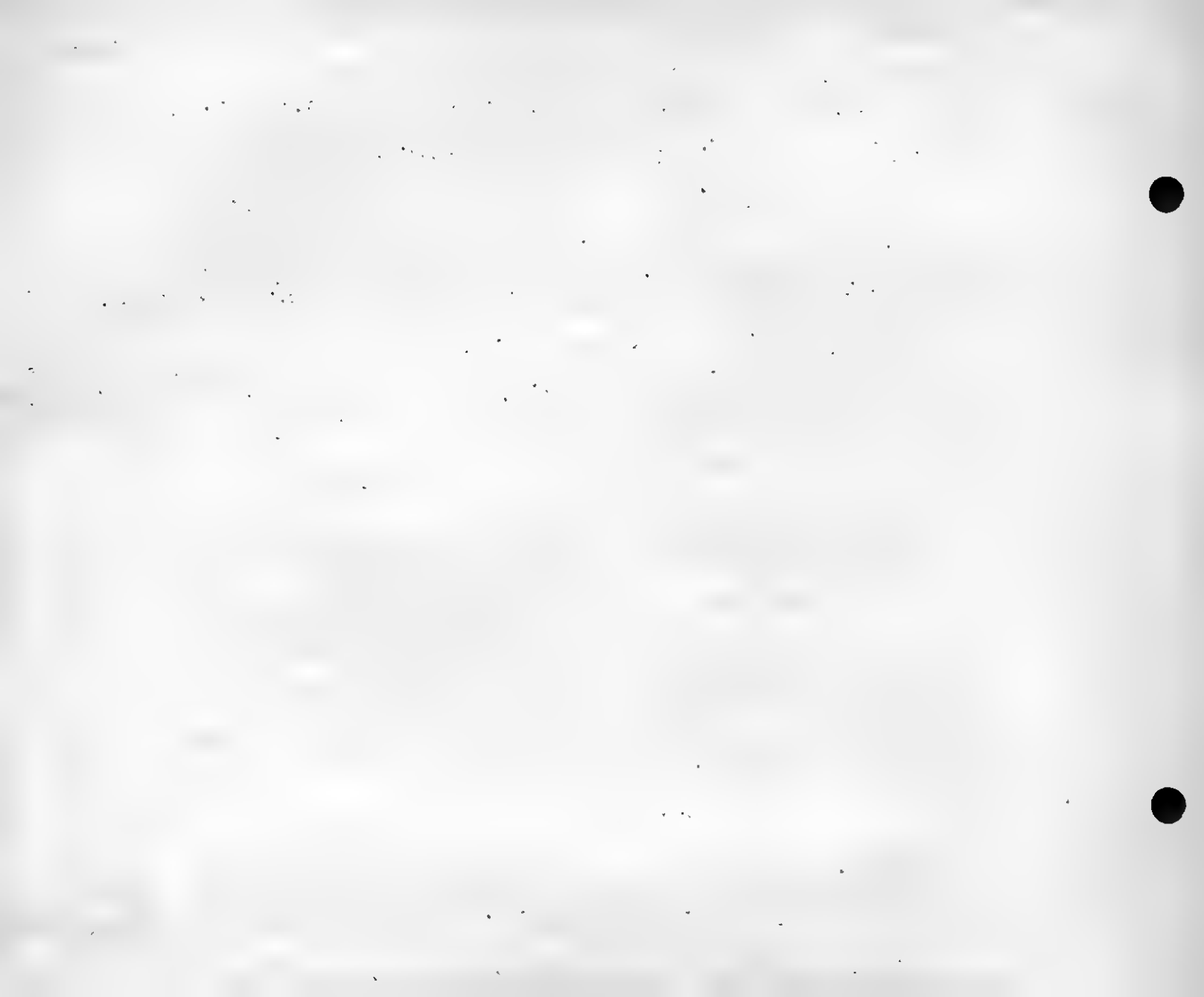
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Edith May Hundley						2a. DATE OF DEATH Month JANUARY Day 7 Year 1968			2b. HOUR 5 A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH JAN. 20, 1916			6. AGE (In years last birthday) 51 YRS.		IF UNDER YEAR MONTHS 5 DAYS 1		IF UNDER 24 HRS. HOURS 5 MIN 0
7a. BIRTHPLACE (State or foreign country) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Hartford Md.					
10. CITY OR TOWN OF DEATH Harre de Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hartford Memorial Hosp			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) HOUSE WIFE			12b. KIND OF BUSINESS OR INDUSTRY HOMIE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b. COUNTY Hartford			13c. CITY OR TOWN Harre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 636 Pearl Street	
14. FATHER'S NAME First JOHN Middle C Last ADAMS				15. MOTHER'S MAIDEN NAME First METTIE Middle FOLEY Last ADAMS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input type="checkbox"/>				16b. SOCIAL SECURITY NO. 1		17. INFORMANT THE VIRGIE V. LOGAN Address 249 LEWIS, ST HARRE DE GRACE, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cong heart failure 4 x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Cor pulmonale. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from JAN 6, 1968 , to JAN 7, 1968 , that (I) (we) last saw the deceased alive on JAN 7, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Lajos Mezei DEGREE MD						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) Dr. Lajos Mezei MD						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JAN. 10, 1968		23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM.				23d. LOCATION (City or Town) (County) (State) HARRE DE GRACE HARTFORD MO.			
24. FUNERAL DIRECTOR R. Madison Mitchell		ADDRESS Harre de Grace, Md.		25a. REC'D BY REGISTRAR JAN 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01003							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF EST- DEATH MATED			2b. HOUR					
Bob							Johnson Jr		January 2 1968			3A					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR			
M		W		9/26/1928		39 YRS						January 2 1968		7:25			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					Md			
Logan Co, KY			U.S.A.						Harford								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Harford, Md.			Harford Mem. Hosp						Came Onsite			Construction					
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Tenn								Springfield									
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First		Middle		Last	
Bob							Johnson		Mildred Irene							Wilson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS					
UNK				UNK				Harford Memorial Hosp				RECORDS					
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Crushing Injury Chest</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?									
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
				3 1-2 68				Dam gates opened + flooded and his car which upset on turn									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or town County State									
				Savage River				conowingo Cecil Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE				EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED					
Gerald P Palmer				Gerald P Palmer M.D.				Bel Air, Md.				1-2-68					
DEPUTY MEDICAL EXAMINER				ADDRESS (Street, city, town, or county)													
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)									
REMOVAL				1/3/1968		ROBERTSON CO. MEM		NASHVILLE		TENN							
24. FUNERAL DIRECTOR				25a. REC'D BY REG. STRAR				25b. REGISTRAR'S SIGNATURE									
Cunnington & Son, Harford, Md.				JAN 5 1968				Charles Judge									

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1000-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print) <i>William A. Riley Keene</i>			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>Jan</i> Day <i>23</i> Year <i>1968</i>		2b. HOUR <i>1:35</i> AM <input checked="" type="checkbox"/> PM	
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>1/20/1933</i>	6 AGE (In years last birthday) <i>35</i> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month <i>1</i> Day <i>23</i> Year <i>1968</i>		2d. HOUR <i>1:35</i> AM	
7a. BIRTH PLACE (State or foreign country) <i>Delm. N.J.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Harris</i>		Md	
10 CITY OR TOWN OF DEATH <i>Home de Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hospital</i>				12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY <i>Trucking</i>	
13a. USUAL RESIDENCE (Where deceased lived admiss an) STATE <i>N.J.</i>		13b. COUNTY <i>Red Bank</i>		13c. CITY OR TOWN <i>Red Bank</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Appt 14 Carlin House</i>	
14. FATHER'S NAME First <i>Clwood</i> Middle <i>Neen</i> Last			15. MOTHER'S MAIDEN NAME First <i>Antude</i> Middle <i>Ackley</i> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>			16b. SOCIAL SECURITY NO. <i>148-22-5361</i>		17 INFORMANT <i>Padgett Linnal</i>		ADDRESS <i>Budgeton N.G.</i>		
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Multiple Injuries</i>									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Auto Accident</i>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <i>US Rt 40</i> City or Town <i>Aberdeen</i> County <i>Har</i> State <i>Md.</i>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		EXAMINER'S NAME (Type) <i>Gerald C Palmer - M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ADDRESS (Street, city, town, or county)		22b. DATE SIGNED <i>1-23-68</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>1/27/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greenwood Mem.</i>		23d. LOCATION (City or Town) <i>Millville, N.J.</i> (County) (State)			
24. FUNERAL DIRECTOR <i>Freemington R. Hanks</i>		ADDRESS <i>Prince Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE		DATE <i>JAN 26 1968</i>	

CERTIFICATE OF DEATH

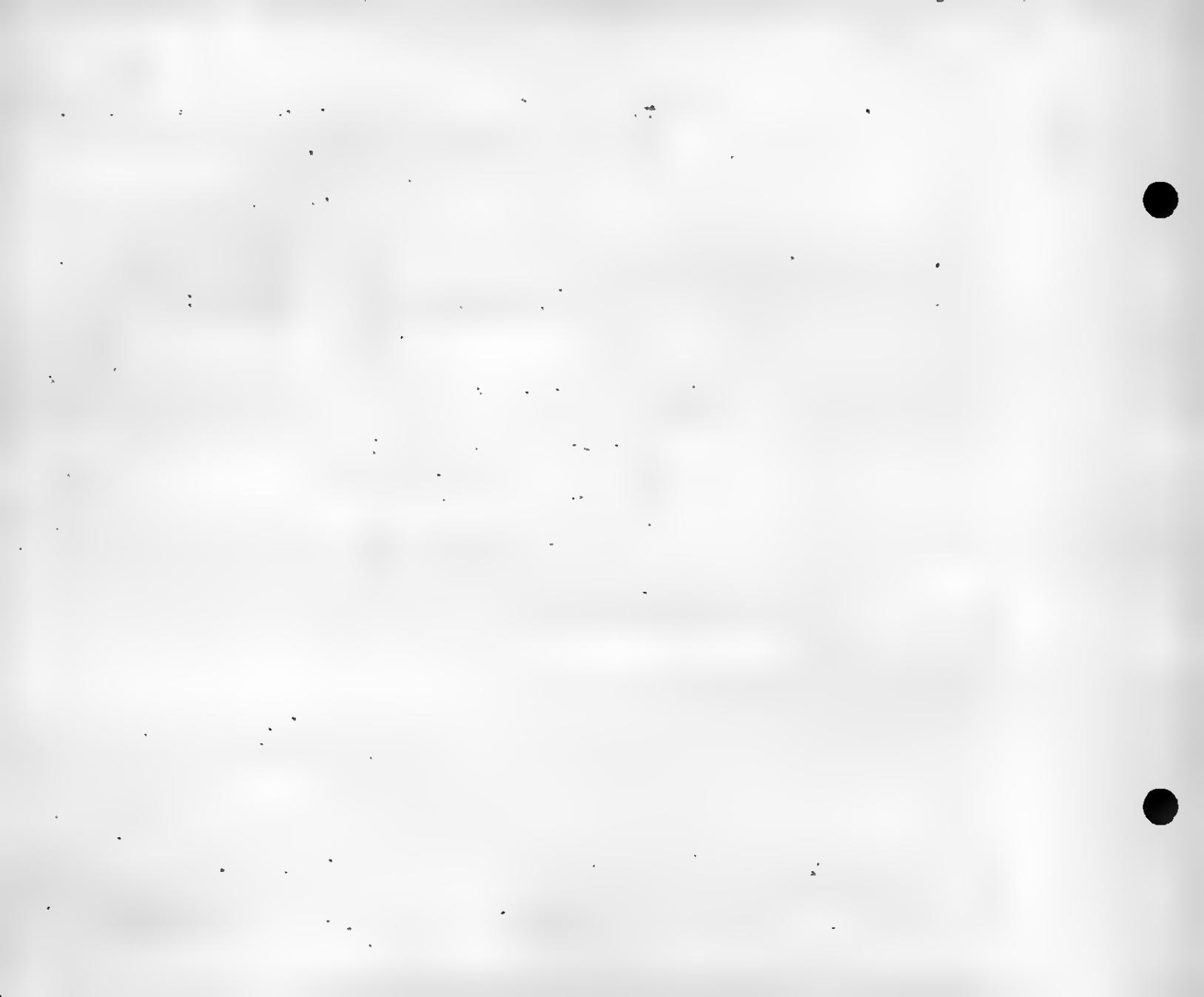
01007

01005

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) Melvin E. Kilgore			2a. DATE OF DEATH Month Jan. Day 20 Year 1968			2b. HOUR 3:40 A.M.	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH January 1, 1897		6. AGE (In years lost birthday) 71 YRS.	
7a. BIRTHPLACE (State or foreign country) Delta, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD	
10. CITY OR TOWN OF DEATH HAURE de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Dairy	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Pa.		13b. COUNTY York		13c. CITY OR TOWN Airville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER R.D. #2		14. FATHER'S NAME First Unknown Middle Unknown Last Unknown		15. MOTHER'S MAIDEN NAME First Hattie Middle Kilgore Last Kilgore		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or of unknown No	
16b. SOCIAL SECURITY NO. 184-05-1587A		17. INFORMANT Mrs. Bessie V. Kilgore		Address R.D. #2 Airville, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion due to 411 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.V.D. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Pneumonitis, Bronchial asthma + Emphysema							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 3-4 years
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION / Street or R.F.D. No. 1/18 City or Town 1/20 County 1968 State 1968			
22a. I certify that (I) (this hospital) attended the deceased from 1/18 , 19 68 , to 1/20 , 19 68 , that (I) (we) last saw the deceased alive on Jan. 20 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edward C. Loo, M.D.		DEGREE EDUCATION		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/20/68	
22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22e. ADDRESS Haure de Grace, Ind.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 23, 1968		23c. NAME OF CEMETERY OR CREMATORY Mt. Nebo Cemetery		23d. LOCATION (City or Town) (County) (State) Delta York Pa.	
24. FUNERAL DIRECTOR John H. Harkins		ADDRESS Delta, Pa.		25a. REC'D BY REGISTRAR DATE JAN 23 1968		25b. REGISTRAR'S SIGNATURE Charles Young	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 111 (11-60)
30M REV. 7-60

01008

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01006

1. DECEASED-NAME (Type or print) First Middle Last <i>James Harry Knight</i>			2a. DATE OF DEATH Month Day Year <i>20 05 1968</i>			2b. HOUR <i>3:35</i> M	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>MAY 21, 1895</i>		6. AGE (In years lost birthday) <i>72</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i> Md.	
10. CITY OR TOWN OF DEATH <i>Harre de Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hospital</i>		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>FARMER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>RETIRED</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>HARFORD</i>		13c. CITY OR TOWN <i>Harre de Grace</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <i>N.D. #2</i>		14. FATHER'S NAME First Middle Last <i>John W. Knight</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Nona Fanthree</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO <i>219-26-3727</i>		17. INFORMANT <i>Dale T. KNIGHT</i>		<i>DARLINGTON ROAD - LEVEL</i> <i>HARRE DE GRACE ROAD #2</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis, left</i> <i>1541</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma, rectum (with widespread metastasis)</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1541</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>3 mos</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Urinary Obstruction due to Benign Hypertrophy Prostate</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1-4</i> , 19 <i>62</i> , to <i>1-20</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>1-20</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Ralph W. Knight</i>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<i>BURIAL</i>		<i>JAN. 23, 1968</i>		<i>DEER CREEK METH. CH. YD.</i>		<i>HARFORD CO MD</i>	
24. FUNERAL DIRECTOR <i>R. MADISON MITCHELL</i>		24b. ADDRESS <i>HARRE DE GRACE MD.</i>		25a. REC'D BY REGISTRAR <i>DATE JAN 25 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delays necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH										Q1007	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										Item 2a Film G397 I/25/68 kk	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Item 2a Film G397 I/25/68 kk	
1 DECEASED-NAME (Type or Print) <i>Mary Elizabeth LaRue</i>			2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 1 12 1968			2b HOUR M					
3 SEX <i>F</i>		4 RACE <i>E</i>		5. DATE OF BIRTH		6 AGE (in years as of birthday) <i>48</i> YRS		7 UNDER YEAR MONTHS DAYS		8. DATE PRONOUNCED DEAD Month <i>Jan</i> Day <i>12</i> Year <i>1968</i>	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <i>Way</i>		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hospital</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>			13b COUNTY <i>Harford Aberdeen</i>			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>410.9 coronary Occlusion</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>42.1</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Gerald E Palmer</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Bel Air, Md</i>				22b. DATE SIGNED <i>1-12-68</i>			
EXAMINER'S NAME (Type) <i>Gerald E Palmer - MD</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE <i>20</i>				23c NAME OF CEMETERY OR CREMATORY <i>Bel Air, Md</i>			
24 FUNERAL DIRECTOR <i>Little</i>				25a REC'D BY REGISTRAR <i>Charles Judge</i>				25b REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01010

01008

1. DECEASED-NAME (Type or print) Ada First Lewis Middle Last			2a. DATE OF DEATH Month January Day 26 Year 1968			2b. HOUR 11:45 P.M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH Dec. 10, 1888		6. AGE (In years last birthday) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Hartford			Md.		
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Hartford Mem. Hosp.			12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.			13b. COUNTY Hartford		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 916 Wakefield Drive		
14. FATHER'S NAME First John Thomas Middle Patterson Last			15. MOTHER'S MAIDEN NAME First Mary Middle Thompson Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address Blanche Ballock, Havre de Grace, Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF (b) Arterial Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Scrub											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from JAN 26, 1968 , to JAN 26, 1968 , that (I) (we) last saw the deceased alive on JAN 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ann L. Waggoner						DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/27/68	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 1-30-1968			23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery			23d. LOCATION (City or Town) (County) (State) Bel Air, Md		
24. FUNERAL DIRECTOR Reed L. Patterson & Son, Inc., Baltimore, Md						25a. REC'D BY REGISTRAR DATE FEB 5 1968		25b. REGISTRAR'S SIGNATURE W. H. [Signature]			

MEDICAL CERTIFICATION

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-24-68 mt 397 Maryland State Department of Health
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01009

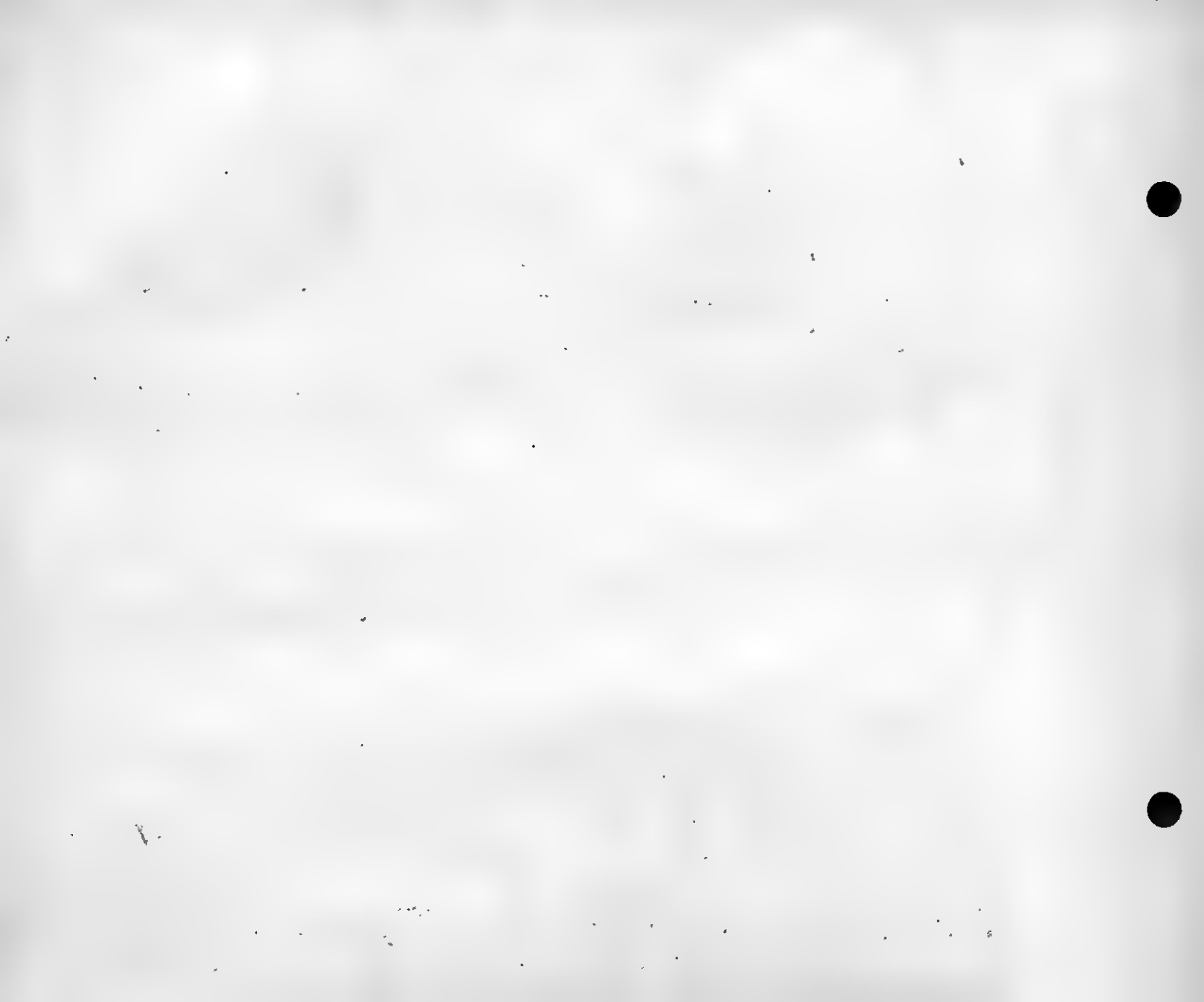
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR			
MARLON		T.		LOCKETT				1		3		1968		3; am					
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		Month		Day		Year			
Male	Colored	7-25-65		2 YRS		5-19-66				1		3		1968		3 am			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH											
Illinois		U.S.A.		WIDOWED		DIVORCED		Harford											
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY													
Aberdeen Proving Ground		Kirk Army Hospital		N/A		N/A													
13a U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER											
Md.		Harford		Edgewood		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6523c Hawthorne, Edgewood											
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last					
Randle		R.		Lockett				Patricia						Young					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		N/A		Father,		same as 13 C & E													
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Peritonitis																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																			
(b) Perforation of the small intestine																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a DATE OF OPERATION																19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?	
																		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 8.)											
				1-2 1968				unknown											
21d INJURY OCCURRED				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or RFD				City or Town							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Home				6523c Hawthorne				Harford							
												Md							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>																			
ACTUAL SIGNATURE				EDWARD F. WILSON				M.D.				22b DATE SIGNED							
EXAMINER'S NAME (Type)				Edward F. Wilson, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>							
								DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street city town, or county)							
23a BURIAL CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)							
Removal				1-4-68				Jefferson Bks. National Cemetery, St Louis, Missouri											
24 FUNERAL DIRECTOR				Tarring Funeral Home				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE							
Walter Macosko Jr.				Aberdeen, Md. 21001				JAN 8 1968				J. Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

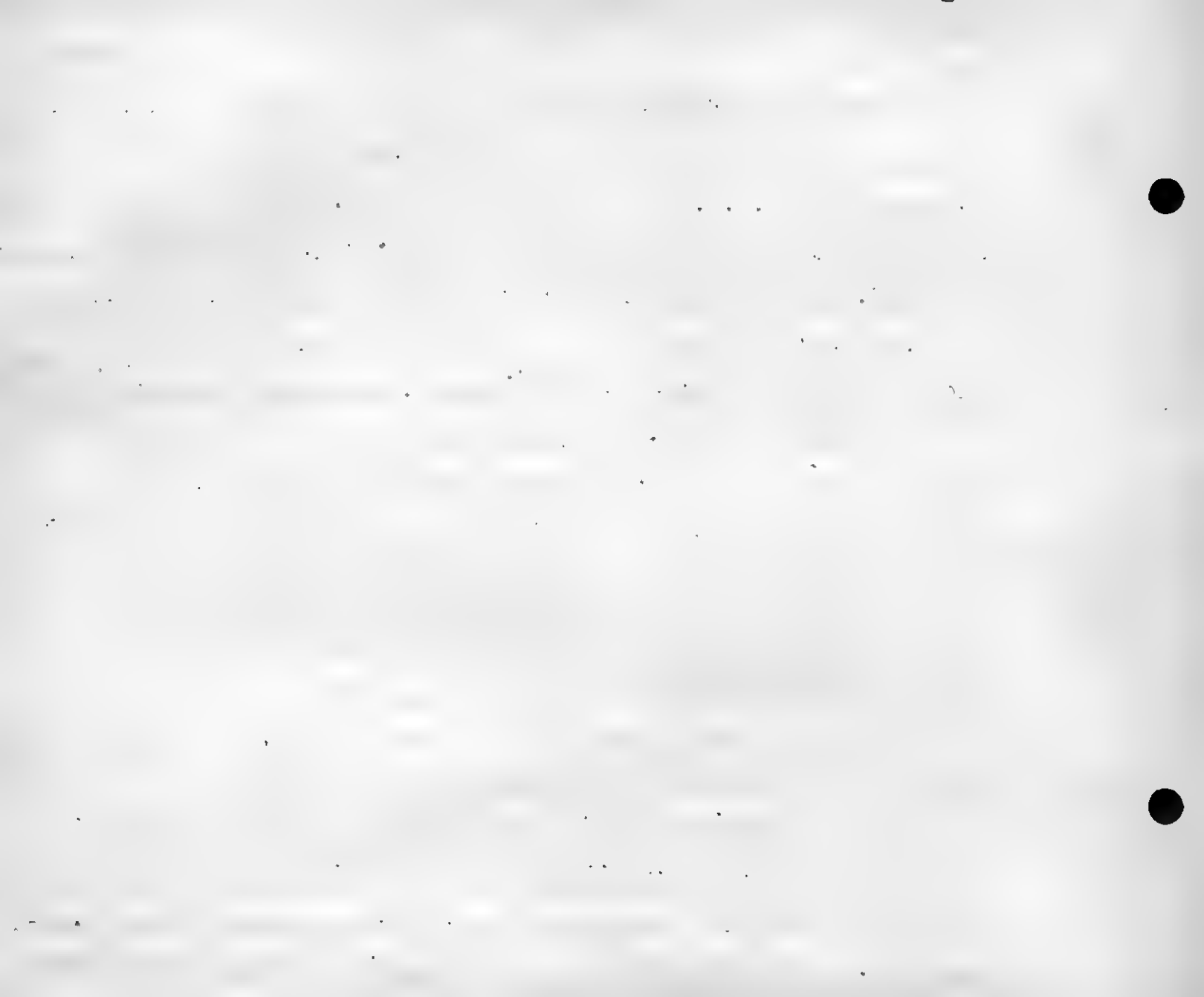
01012				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01011			
1 DECEASED-NAME (Type or print)				2a. DATE OF DEATH				2b. HOUR			
Benjamin HARRISON McCloud				January 13, 1968				4:15 P.M.			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		7 UNDER 1 YEAR		8 IF UNDER 24 HRS	
Male		White		10-8-1888		79 YRS		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b. CIT. ZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Va		U.S.				HARFORD		Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
HARFORD GRACE		HARFORD Memorial		laborer							
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md		HARFORD		Port Deposit				P.O. Box 17			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address	
James		McCloud		Sally		223-12-7509		Mrs. Frances V. Hayes		Port Deposit, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4431		C.V.A.		H.C.V.D.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4431											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from JAN 5, 1968, to JAN 13, 1968, that (I) (we) last saw the deceased alive on JAN 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
Lajos I. MEZEI								1-13-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. DATE SIGNED							
Lajos I. MEZEI		Harford Grace, Md.		25. REC'D BY REGISTRAR							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		25b. REGISTRAR'S SIGNATURE			
Burial		1/16/1968		Popwell Cemetery		Port Deposit Cecil, Md		25c. DATE SIGNED			
24. FUNERAL DIRECTOR		25a. ADDRESS		25b. REGISTRAR'S SIGNATURE		25c. DATE SIGNED		25d. REGISTRAR'S SIGNATURE			
Lee G. Gattison		Senyville, Md		25b. REGISTRAR'S SIGNATURE		25c. DATE SIGNED		25d. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

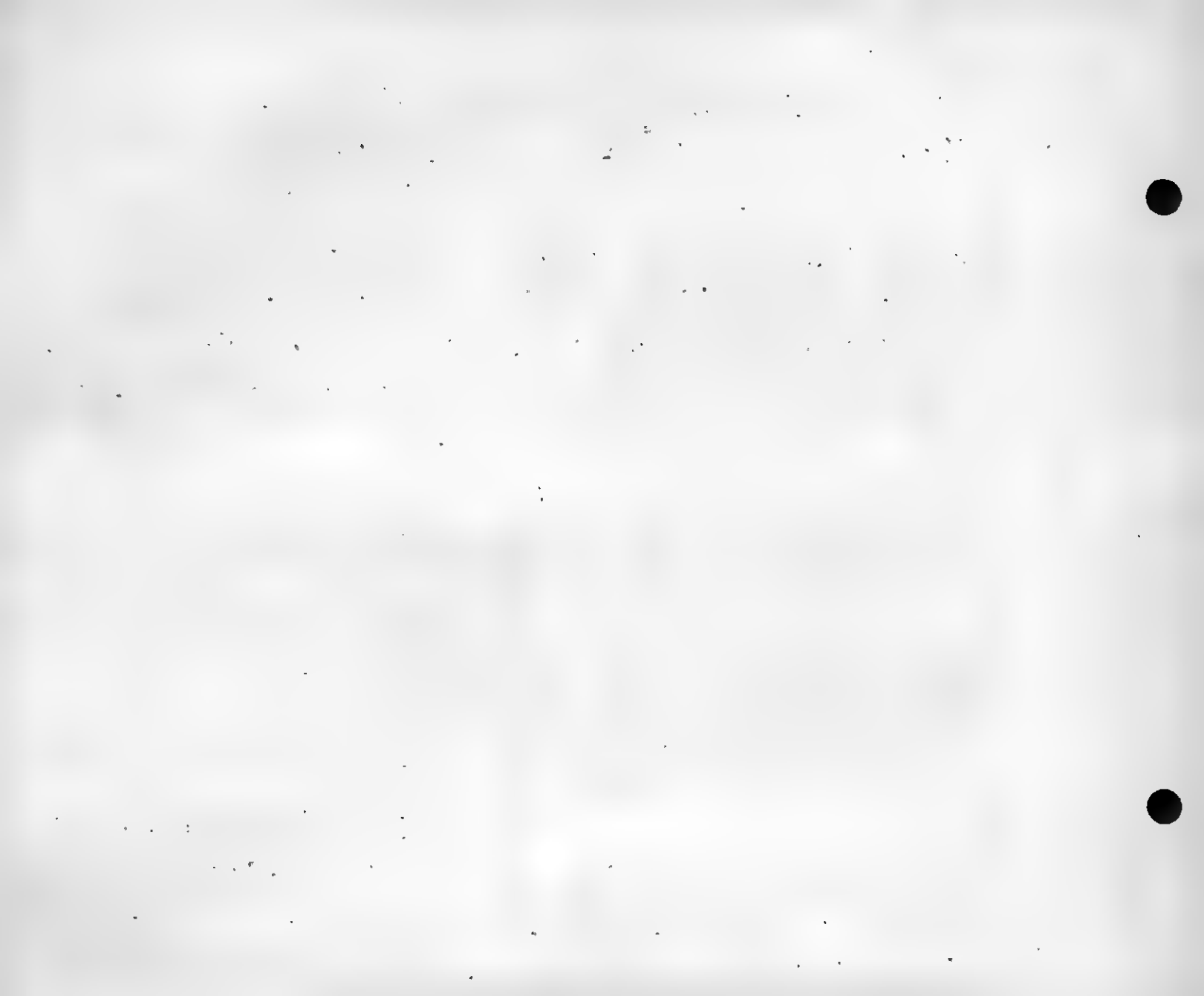
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Robert Marshall McFadden						2a. DATE OF DEATH January 4th 1968			2b. HOUR 9:45 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11/29/1885		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md					
10. CITY OR TOWN OF DEATH Jarrettsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miller		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farm Product				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Jarrettsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Baldwin Mill Road			
14. FATHER'S NAME First Middle Last John Wesley McFadden				15. MOTHER'S MAIDEN NAME First Middle Last Louisa Jeffrey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) ---				16b. SOCIAL SECURITY NO 213-01-3759				17. INFORMANT Mrs. Hannah A. McFadden Address Md. 21084 Jarrettsville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO-RESP FAILURE										24 HRS	
DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED METASTATIC MALIGNANCY										1 MO.	
DUE TO, OR AS A CONSEQUENCE OF (c) UNDIFF. CA. OR SARCOMA RT FEMUR										3 MO.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION ---		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1961 , to 2 JAN 1968 , that (I) (we) last saw the deceased alive on 2 JAN 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE H.P. Sidwell M.D.		DEGREE ---		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5 JAN 68					
22d. PHYSICIAN'S NAME (Type) H.P. SIDWELL M.D.		22e. ADDRESS 401 Preston St. Baltimore Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/6/1968		23c. NAME OF CEMETERY OR CREMATORY Fawn Grove Methodist		23d. LOCATION (City or Town) (County) (State) Fawn Grove York, Penna.					
24. FUNERAL DIRECTOR Charles E. Kurtz Jarrettsville, Md.				25a. REC'D BY REGISTRAR Charles E. Kurtz		25b. REGISTRAR'S SIGNATURE Charles E. Kurtz					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
01014		CERTIFICATE OF DEATH						01013	
1. DECEASED NAME (Type or print) <i>Baby Boy Miller</i>					2a. DATE OF DEATH Month <i>JAN</i> Day <i>5</i> Year <i>1968</i>			2b. HOUR <i>3:50A M</i>	
3 SEX <i>Male</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>1/14/1968</i>		6 AGE (In years last birthday) YRS <i>-</i> MONTHS <i>-</i> DAYS <i>1</i> HOURS <i>8</i> MIN.		IF UNDER 1 YEAR MONTHS <i>-</i> DAYS <i>-</i> HOURS <i>-</i> MIN.	
7a. BIRTHPLACE (State or foreign country) <i>md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i> Md.			
10. CITY OR TOWN OF DEATH <i>Harre-de-Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>none</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>none</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>md</i>		13b. COUNTY <i>harford</i>		13c. CITY OR TOWN <i>Bel Air</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>St. 2, Box 131</i>	
14. FATHER'S NAME First <i>James Lonnie</i> Middle <i>Miller</i> Last <i>Chyne</i>				15. MOTHER'S MAIDEN NAME First <i>Dore</i> Middle <i>Gum</i> Last <i>Gum</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>James L. Miller, Rt. 2, Box 131-7, Bel Air, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory insufficiency</i> <i>1761</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hyaline membrane disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Prematurity - C-section - pre-diabetic mother</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>-</i> Month <i>-</i> Day <i>-</i> Year <i>19</i> P.M. <i>-</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No <i>-</i> City or Town <i>-</i> County <i>-</i> State <i>-</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>4 Jan, 1968</i> , to <i>5 Jan, 1968</i> , that (I) (we) last saw the deceased alive on <i>5 Jan 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Harold Brenner</i>		DEGREE <i>-</i> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>Jan. 5, 1968</i>					
22d. PHYSICIAN'S NAME (Type) <i>Harold Brenner, M.D.</i>		22e. ADDRESS <i>Harre de Grace, Maryland</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Jan. 8, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bel Air Memorial Gardens</i>		23d. LOCATION (City or Town) (County) (State) <i>Bel Air Harford Md</i>			
24. FUNERAL DIRECTOR <i>Howard K. McComas</i>		ADDRESS <i>Son, Abingdon, Md. 21006</i>		25a. REC'D BY REGISTRAR <i>DATE JAN 10 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

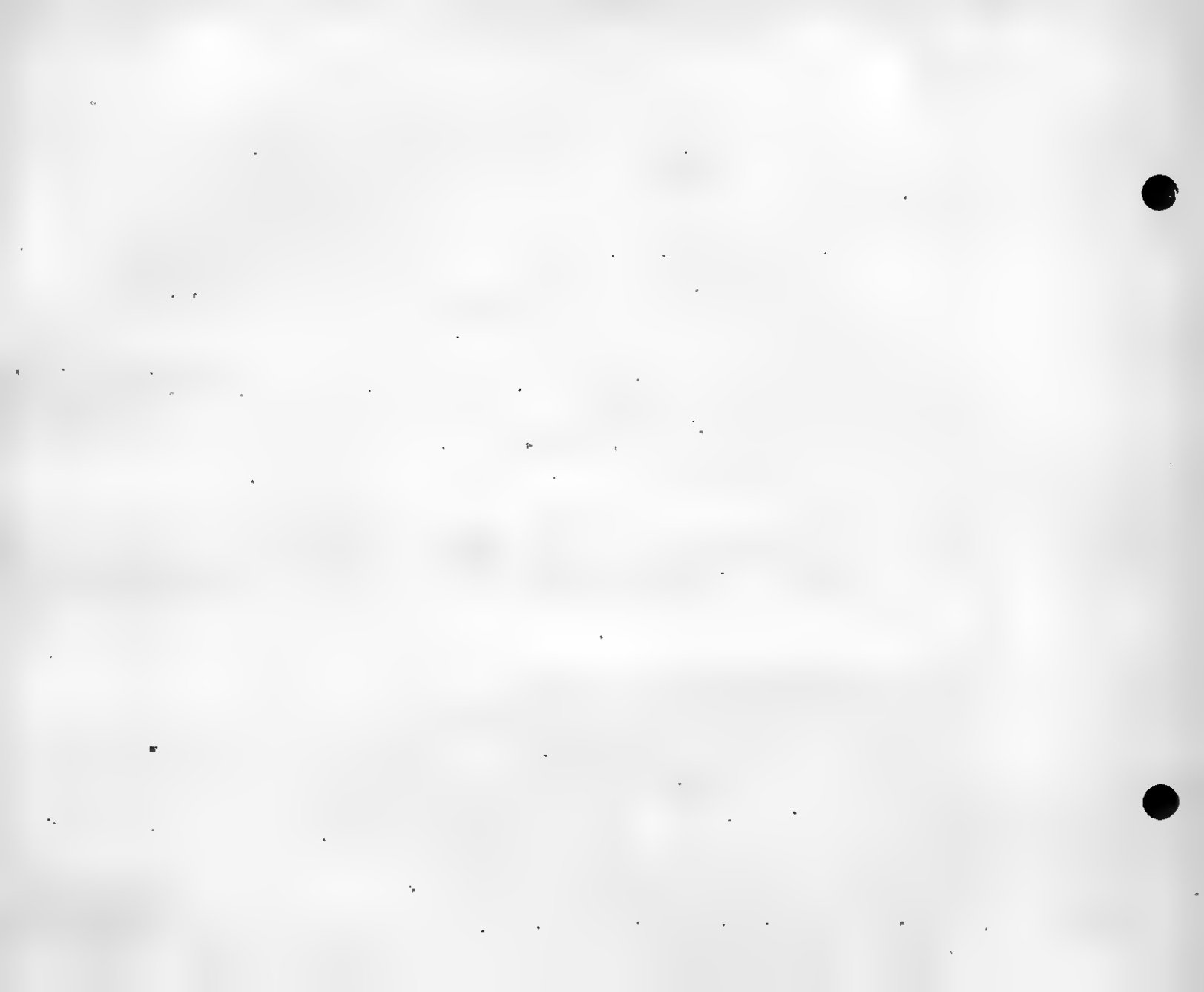
01014

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - HAVRE DE GRACE</u> c. LENGTH OF STAY IN 1b <u>75 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R.D. #2 Box 186</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - HAVRE DE GRACE - 21055</u> d. STREET ADDRESS <u>R.D. #2 Box 186</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>NELLIE GRACE MILLER</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>27</u> Year <u>1968</u>		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>DEC. 11, 1869</u> 9. AGE (In years last birthday) <u>98</u> IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> 11. BIRTHPLACE (Country & State, or foreign country) <u>BALTO. MD.</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN COGGINS</u> 14. MOTHER'S MAIDEN NAME <u>ANGELINE</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>218-54-4375</u> 17. INFORMANT <u>ROTH M. GRAHAM</u> Address <u>R.D. #2 Box 186 HAVRE DE GRACE MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> (b) <u>Arterio sclerosis - General debility</u> (c) <u>General debility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1938</u> 19 , to <u>1-24-68</u> 19 , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>R. Madison Mitchell</u>		22b. DATE SIGNED <u>MD</u>		22c. PHYSICIAN'S NAME (Type) <u>R. L. LEWIS MD</u>			
22d. ADDRESS <u>HAVRE DE GRACE MD</u>		22e. REC'D BY REGISTRAR 22f. REGISTRAR'S SIGNATURE <u>R. Madison Mitchell</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>JAN 2, 1968</u> 23c. NAME OF CEMETERY OR CREMATORY <u>WESLEYAN CHAPEL CEM</u> 23d. LOCATION (City, town or county) (State) <u>HARFORD, CO. MD</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>HAVRE DE GRACE MD</u> <u>DATE JAN 30 1968</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

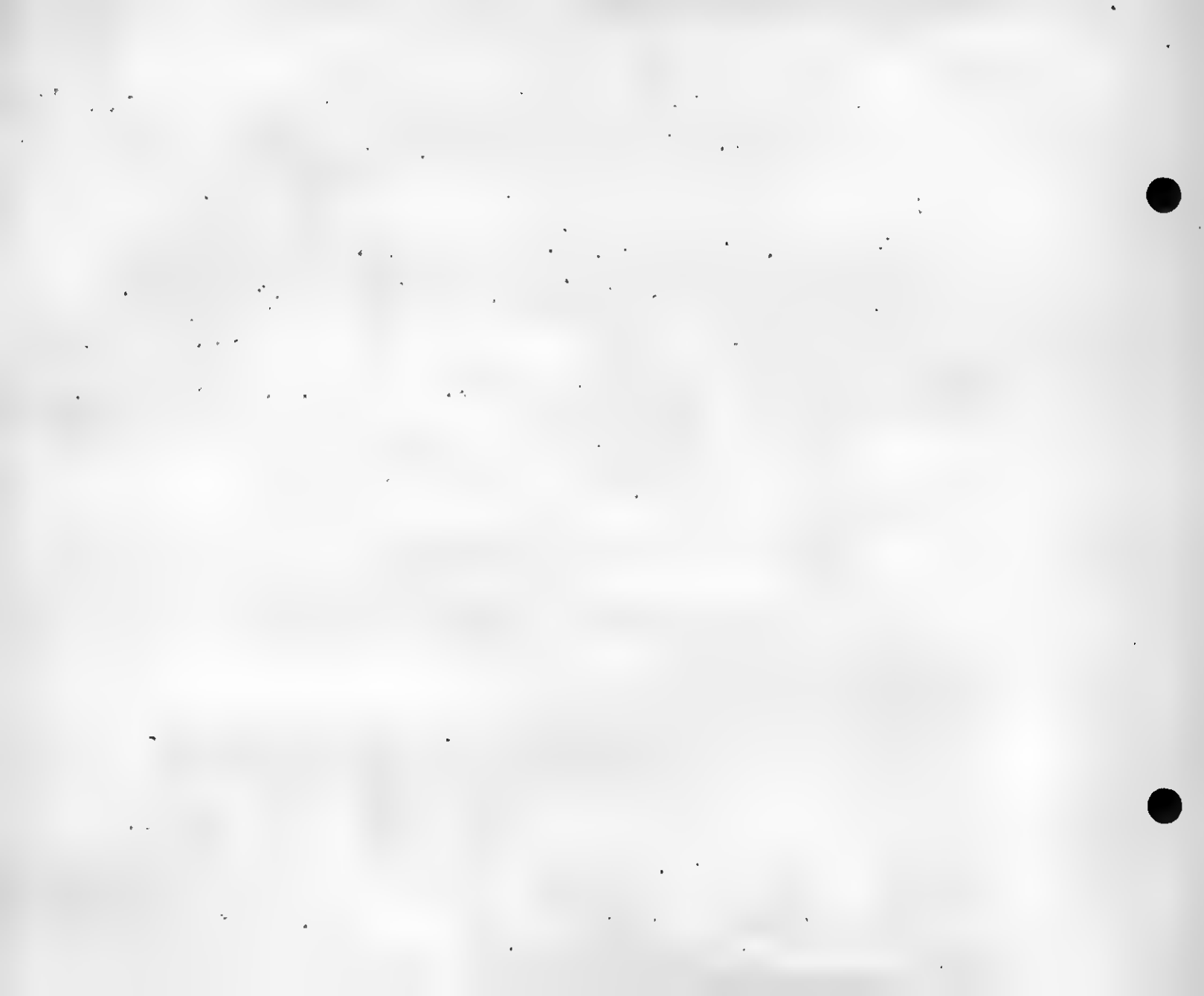
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
KATE			-- MITCHELL			Month Day Year January 25 1968			1:30 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS HOURS MIN.
Female		White		May 17, 1883			84 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
altimore, Md		USA				HARFORD Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Bel Air - R.D.			Harford Convalescent Home			Housewife		--	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Harford		Churchville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 40, Rt. 1
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Unknown			Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			212-22-8055-A		George A. Mitchell, Box 40, Rt. 1, Churchville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Par-Kinson's Disease</u>									
342X DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
350X Epilepsy									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10-25, 1966, to 1-25, 1968, that (I) (we) last saw the deceased alive on 1-26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Lorald & Palmer						22c. DATE SIGNED 1-25-68			
22d. PHYSICIAN'S NAME (Type) Gerald & Palmer						22e. ADDRESS Bel Air, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)		
Burial			Jan. 27, 1968		Calvary Methodist Cemetery		Churchville Harford Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Howard K. McComas & Son, Abingdon, Md. 2100			DATE JAN 29 1968			Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) Edith Rachel Oliver						2a DATE OF DEATH JANUARY 24 1968			2b HOUR 4 19 A.M.		
3 SEX Female		4 RACE White		5. DATE OF BIRTH 18 Sept. 1879		6. AGE (In years last birthday) 88 YRS		7 UNDER YEAR MONTHS		7 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Pa.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Hartford Md					
10 CITY OR TOWN OF DEATH Havre de Grace				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hartford Mem. Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b KIND OF BUSINESS OR INDUSTRY Home		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md				13b COUNTY Hartford		13c CITY OR TOWN Aberdeen		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1940 Park Beach Dr.	
14 FATHER'S NAME First Samuel Middle P. Last Ryan				15 MOTHER'S MAIDEN NAME First Sarah Middle Frances Last Dawson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 220-144-9801		17. INFORMANT Address Frank L. Oliver, Rt. 3, Aberdeen, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bacterial Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Senility INAMINATION ASHD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4712										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1-15 , 19 68 , to 1-24 , 19 68 , that (I) (we) last saw the deceased alive on 1-24 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Mahmoud M. H. W. ISHAK, MD				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1-24-68					
22d. PHYSICIAN'S NAME (Type) H. W. ISHAK, MD				22e. ADDRESS 504 Lewis Street Ham Del Mar Rd 21078							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 27 Jan. 68		23c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery,		23d. LOCATION (City or Town) (County) (State) R.D. Bel Air, Maryland					
24 FUNERAL DIRECTOR Walter Wescorbin Jr.						25a. REC'D BY REGISTRAR Tarring Funeral Home		25b. REGISTRAR'S SIGNATURE James J. Judge		DATE JAN 26 1968	

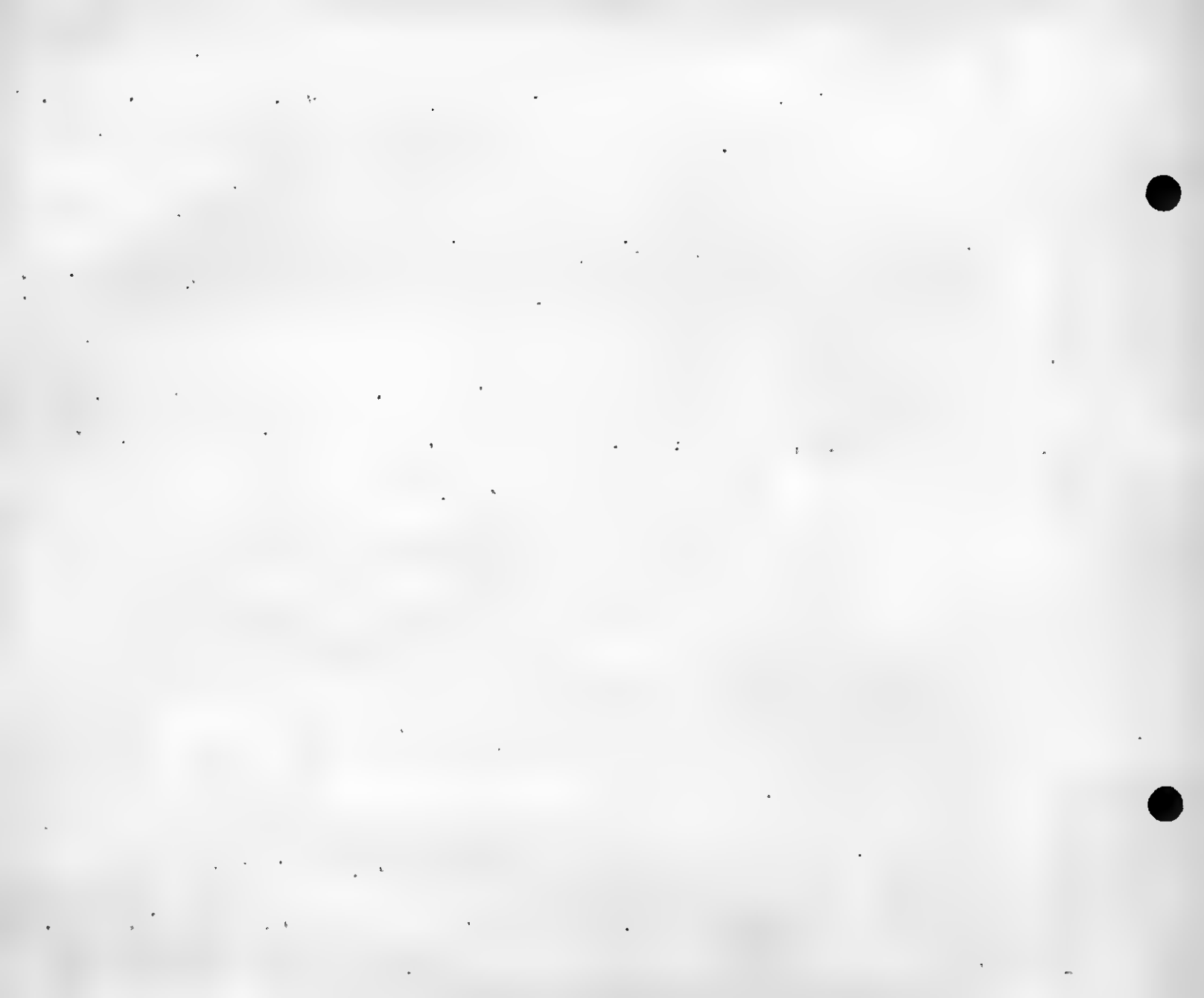


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VR A15
30M REV. 1-60

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
01017												
01018												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR			
MARY MAY PAYNE						JANUARY Month 7 Day 68 Year			12 ⁰⁵ P.M.			
3. SEX		RACE		5. DATE OF BIRTH			6 AGE (in years last birthday)		7 UNDER 1 YEAR		8 UNDER 24 HRS	
Female		White		2-18-1873			94 YRS.		MONTHS		DAYS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Penn'a		USA					HARFORD Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
HAURE DE GRACE			HARFORD MEMORIAL HOSP									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md.			HARFORD			Bel Air		YES		604 Wendelwood Drive		
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
Noah Heiss			Mary Brandt									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
No						Mrs Velma Armacost			21014			
						604 Wendelwood Drive						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) 4109										2 day		
DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D.												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
			HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 6, 1968, to JANUARY 7, 1968, that (I) (we) lost saw the deceased alive on JANUARY 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			22c. DATE SIGNED									
John D. Yum			1/7/68									
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS									
JOHN D. YUM			HAURE DE GRACE									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			1-10-1968			Parkwood Cemetery			Baltimore Co. Md.			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
John A. Funeral Home			JAN 10 1968			Charles Judge						

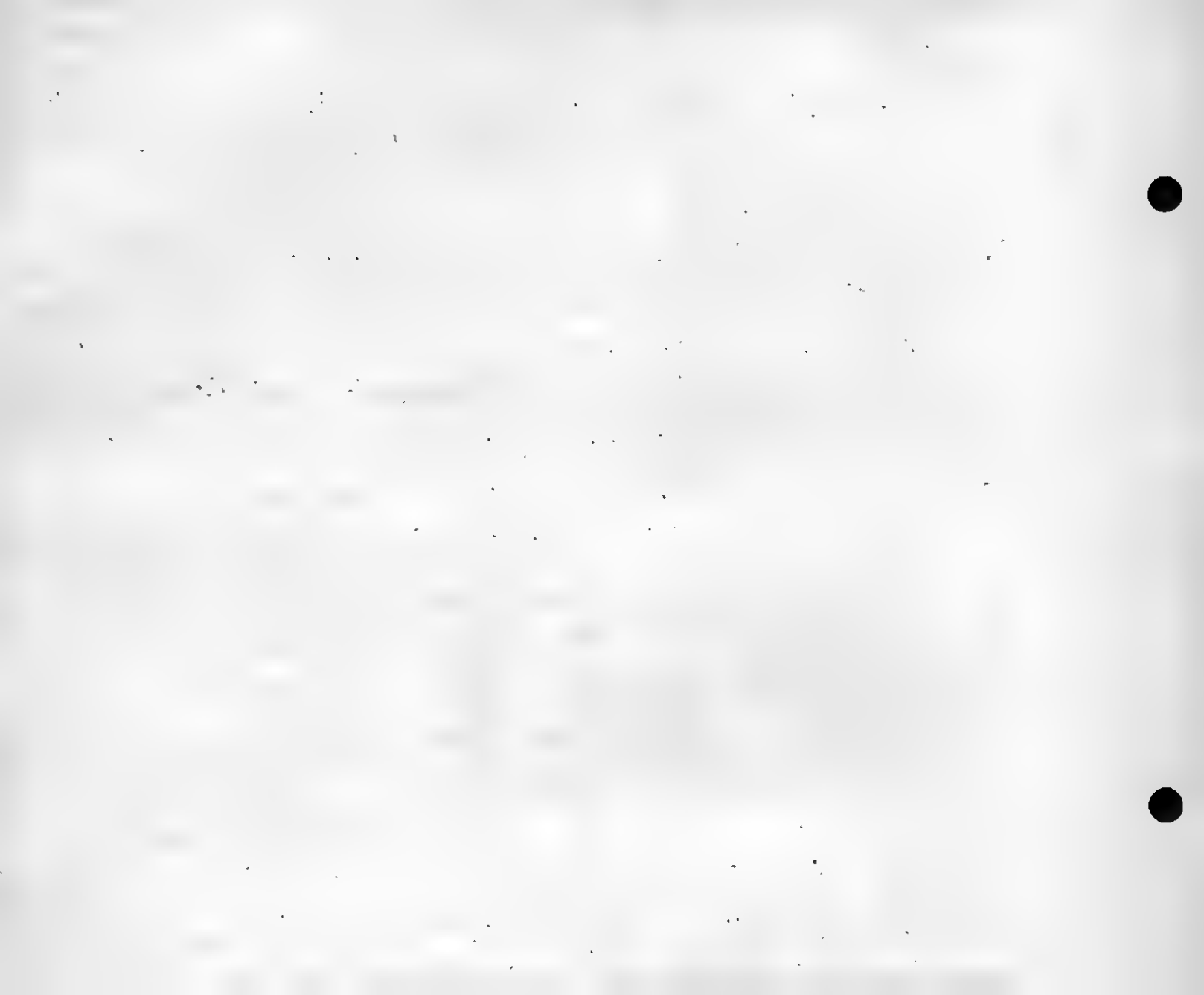


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VR 141 (4)
30M RE 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) ^{First} <u>DAVID</u> ^{Middle} <u>BARRY</u> ^{Last} <u>PETERMAN</u>			2a DATE OF DEATH Month <u>JANUARY</u> Day <u>15</u> Year <u>1968</u>			2b HOUR <u>10</u> PM			
3 SEX <u>Male</u>		4 RACE <u>White</u>		5 DATE OF BIRTH <u>JAN. 15, 1968</u>		6 AGE (In years lost birthday) YRS. <u>0</u> MONTHS <u>0</u> DAYS <u>0</u>		IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN <u>0</u>	
7a BIRTHPLACE (State or foreign country) <u>CECIL, MD</u>		7b CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Harford</u> Md			
10 CITY OR TOWN OF DEATH <u>Harrods Grace</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Harford Memorial Hospital</u>		12a USUAL OCCUPATION (Kind of work done during most of working life-even if retired.) <u>NONE</u>		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>		13b COUNTY <u>CECIL</u>		13c CITY OR TOWN <u>CHARLESTOWN</u>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
14 FATHER'S NAME ^{First} <u>WAYNE</u> ^{Middle} <u>ALLEN</u> ^{Last} <u>PETERMAN</u>			15 MOTHER'S MAIDEN NAME ^{First} <u>JANET</u> ^{Middle} <u>M.</u> ^{Last} <u>BEAL</u>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give war or dates of service)		16b SOCIAL SECURITY NO. <u>NONE</u>		17 INFORMANT <u>WAYNE A. PETERMAN</u>		Address <u>CHARLESTOWN MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>766.4 ASPHYXIA NEONATORUM</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>INTRA-UTERINE ANOXIA 'BANDL'S' CONTRACTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DOUBLE-FETTING BREACH.</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 MIN</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/15/68</u> , 19 <u>68</u> , to <u>1/15/68</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>1/15/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Leo P. J. Belletani</u>		DEGREE <u>MD</u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>1/15/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>LIC PRO J. BELLETANI</u>		22e. ADDRESS <u>HARRODS GRACE, MD.</u>							
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE <u>1/18/68</u>		23c NAME OF CEMETERY OR CREMATORY <u>CHARLESTOWN CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>CHARLESTOWN CECIL MD.</u>			
24 FUNERAL DIRECTOR <u>GRANT FUNERALS</u>		ADDRESS <u>NORTH EAST MD.</u>		25a. REC'D BY REG STRAR DATE <u>JAN 19 1968</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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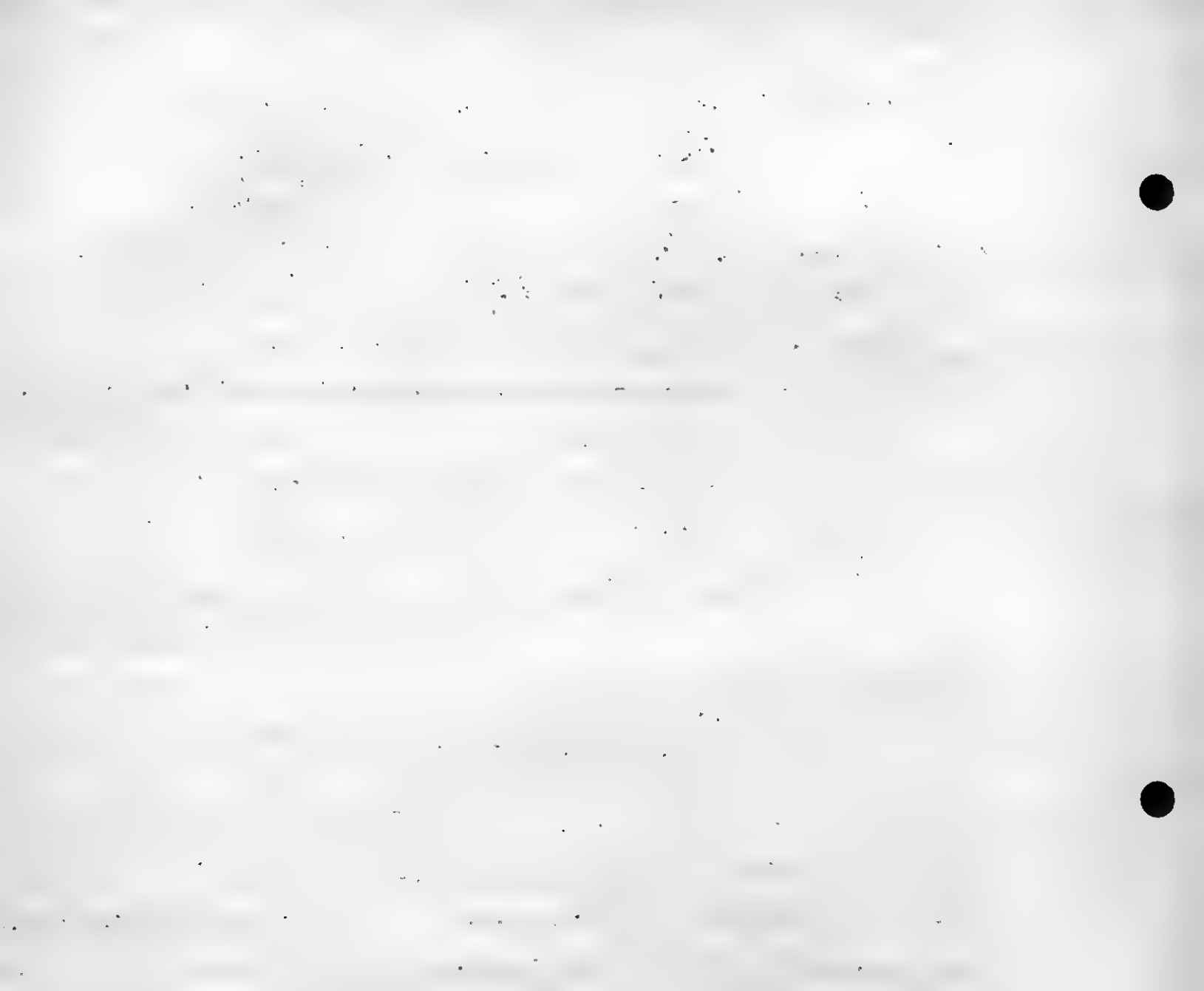
1

01020

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01019

1. DECEASED-NAME (Type or print) Margaret Marie Presbury			2a. DATE OF DEATH Month January Day 23 Year 1968			2b. HOUR 1:10 A					
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH Sept. 25, 1903		6. AGE (in years last birthday) 64 YRS		7. UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN			
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.					
10. CITY OR TOWN OF DEATH Harre de Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md			13b. COUNTY Harford			13c. CITY OR TOWN Forest Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 32	
14. FATHER'S NAME First Jacob H. Middle Greene Last Greene			15. MOTHER'S MAIDEN NAME First Florence Middle Kell Last Kell								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No (If yes give war or dates of service) ---			16b. SOCIAL SECURITY NO. 218-22-0728			17. INFORMANT Robert L. Presbury			Address Forest Hill, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4120 Aneurysm DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular DUE TO, OR AS A CONSEQUENCE OF (c) Renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last > 1 year									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) Hyperthyroidism											
19a. DATE OF OPERATION ---			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? ---		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. --- P.M. --- Month --- Day --- Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.) ---					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) ---			21f. LOCATION Street or R.F.D. No. --- City or Town --- County --- State ---					
22a. I certify that (I) (this hospital) attended the deceased from 12-30, 1968 , to 1-23, 1968 , that (I) (we) lost saw the deceased alive on 1-23, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edward C. Loo, M.D.			DEGREE ---			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 1/23/68		
22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.			22e. ADDRESS Harre de Grace, Ind.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 1/26/1968			23c. NAME OF CEMETERY OR CREMATORY Fairview A.M.E.			23d. LOCATION (City or Town) (County) (State) Forest Hill, Harford, Md.		
24. FUNERAL DIRECTOR Charles E. Kurtz			ADDRESS Jarrettsville, Md.			25a. REC'D BY REGISTRAR DATE JAN 25 1968			25b. REGISTRAR'S SIGNATURE Charles E. Kurtz		

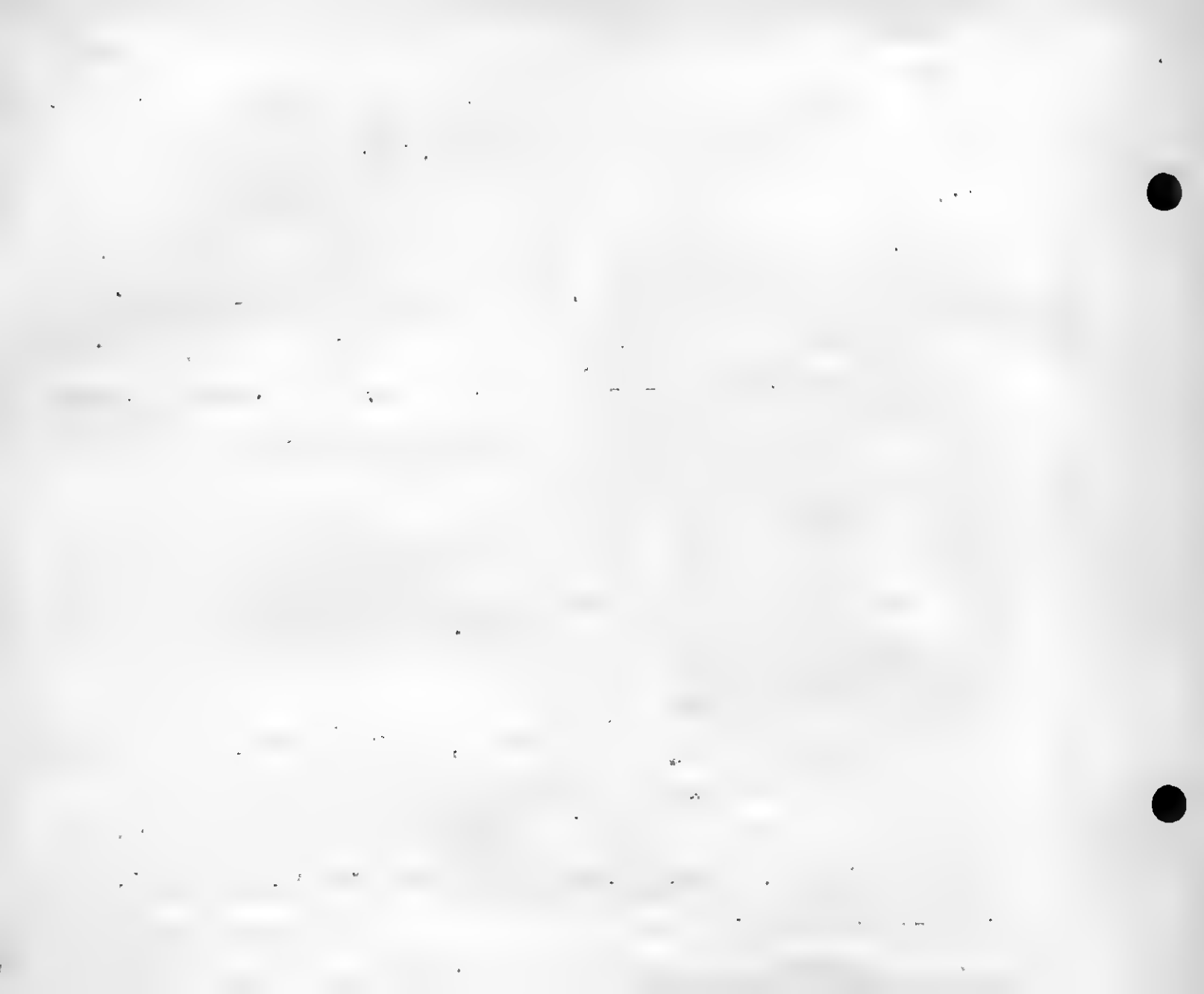


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
01020												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR			
LUDWIG			PROSS			JANUARY 31 1968			225A			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		CAUCASIAN		May 22, 1904			83 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.			
New Jersey		USA				HARFORD						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during last working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
ABERDEEN		Kirk Army Hospital				SOLDIER			RETIRED			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission to State)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND			Harford		Edgewood				2026 Armstrong St			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last									
Kenneth Pross			SOPHIA MATERLA									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT Address							
YES			6 AUG 31 / 7 MAR 63		221-26-2516 JEANETTE PROSS/W/ 2026 Armstrong St, Edgewood							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Pulmonary Edema & Heart Failure</u> 517.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 Min		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, off of building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (do not) attended the deceased from JAN 31, 1968, to JAN 31, 1968, that (I) (do not) saw the deceased alive on JAN 31, 1968, and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.												
22b. SIGNATURE <i>William W. Babson</i>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED JAN 31, 1968				
22d. PHYSICIAN'S NAME (Type) WILLIAM W. BABSON, CPT, MC						22e. ADDRESS KIRK ARMY HOSPITAL, ABERDEEN PG, MD						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCAT ON (City or Town) (County) (State)				
Removal - Burial 1/31/68		1/31/68						Georgetown, Delaware				
24. FUNERAL DIRECTOR Tarring Funeral Home. Aberdeen, Maryland 21004						25a. REC'D BY REGISTRAR DATE FEB 2 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

MEDICAL CERTIFICATION



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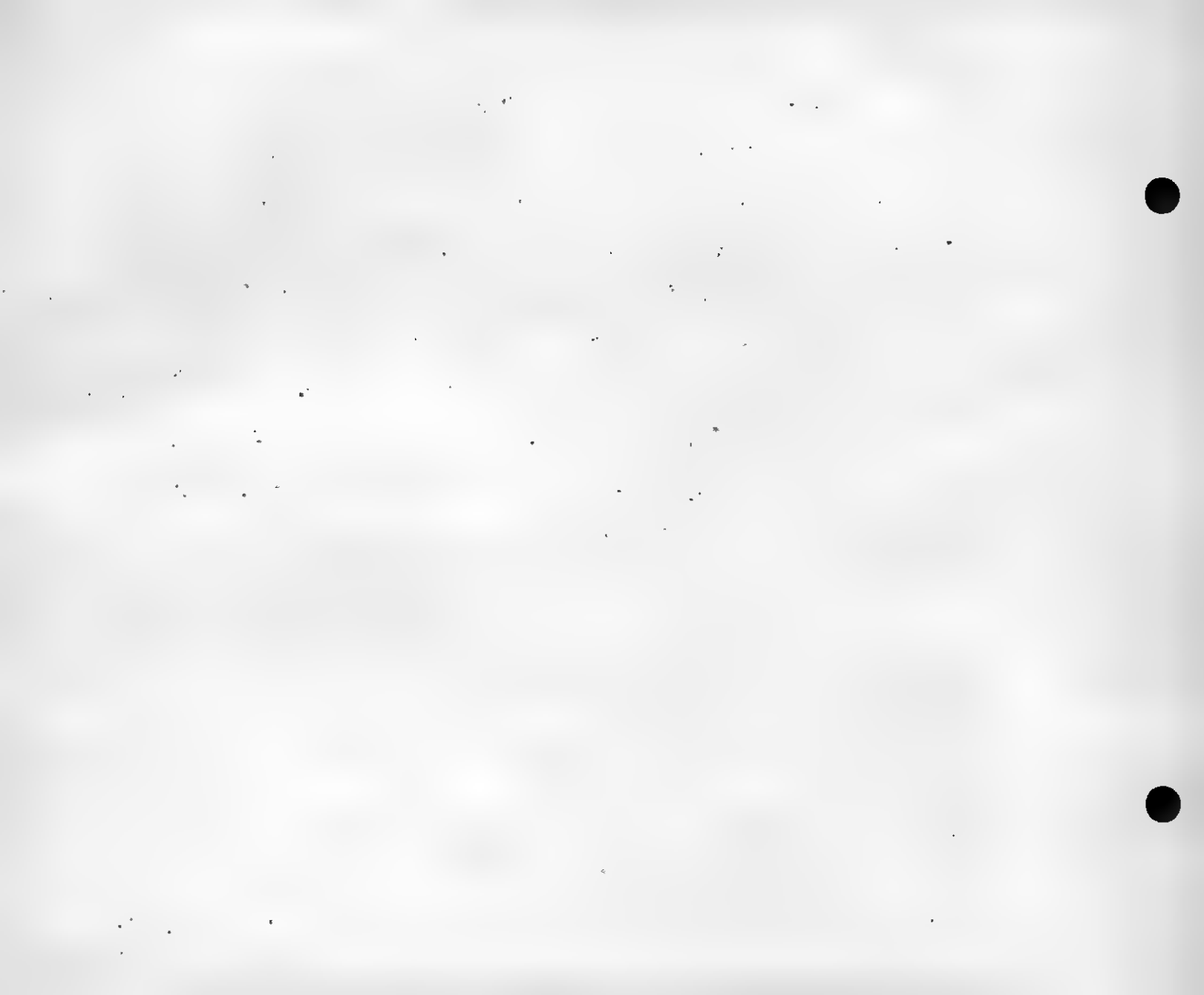
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01022

01021

1 DECEASED NAME (Type or print) MABEL MALINDA PURCELL			2a DATE OF DEATH Month Day Year January 31 1968			2b HOUR 3:00 P.M.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH Feb. 5, 1881		6 AGE (in years last birthday) 86 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.			
10. CITY OR TOWN OF DEATH Bel Air		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Convalescent Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY none			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTY Harford		13c CITY OR TOWN Bel Air		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 207 Mulford Ave., Bel Air, Md.	
14 FATHER'S NAME First Middle Last Millard F. McGonigall			15 MOTHER'S MAIDEN NAME First Middle Last Sarah Stillwell						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-32-2024		17. INFORMANT Address el Air, Md. Martin Millard Purcell, 207 Mulford Ave.,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis CVD disease</u> 412.9 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary path fact - both</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hips</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 412.21									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7-1-68, to 1-31-68, that (I) (we) last saw the deceased alive on 1-29-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Gerald C. Palmer M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 2-1-68			
22d. PHYSICIAN'S NAME (Type) Gerald C. Palmer, M.D.		22e ADDRESS Bel Air, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 3, 1968		23c. NAME OF CEMETERY OR CREMATORY Centre Cemetery		23d. LOCATION (City or Town) (County) (State) Forest Hill Harford Md			
24. FUNERAL DIRECTOR Howard L. McCones		Son, Abin don, Md. 21003		25a. REC'D BY REGISTRAR DATE FEB 2 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



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VR 475 (1)
30M REV 1/68

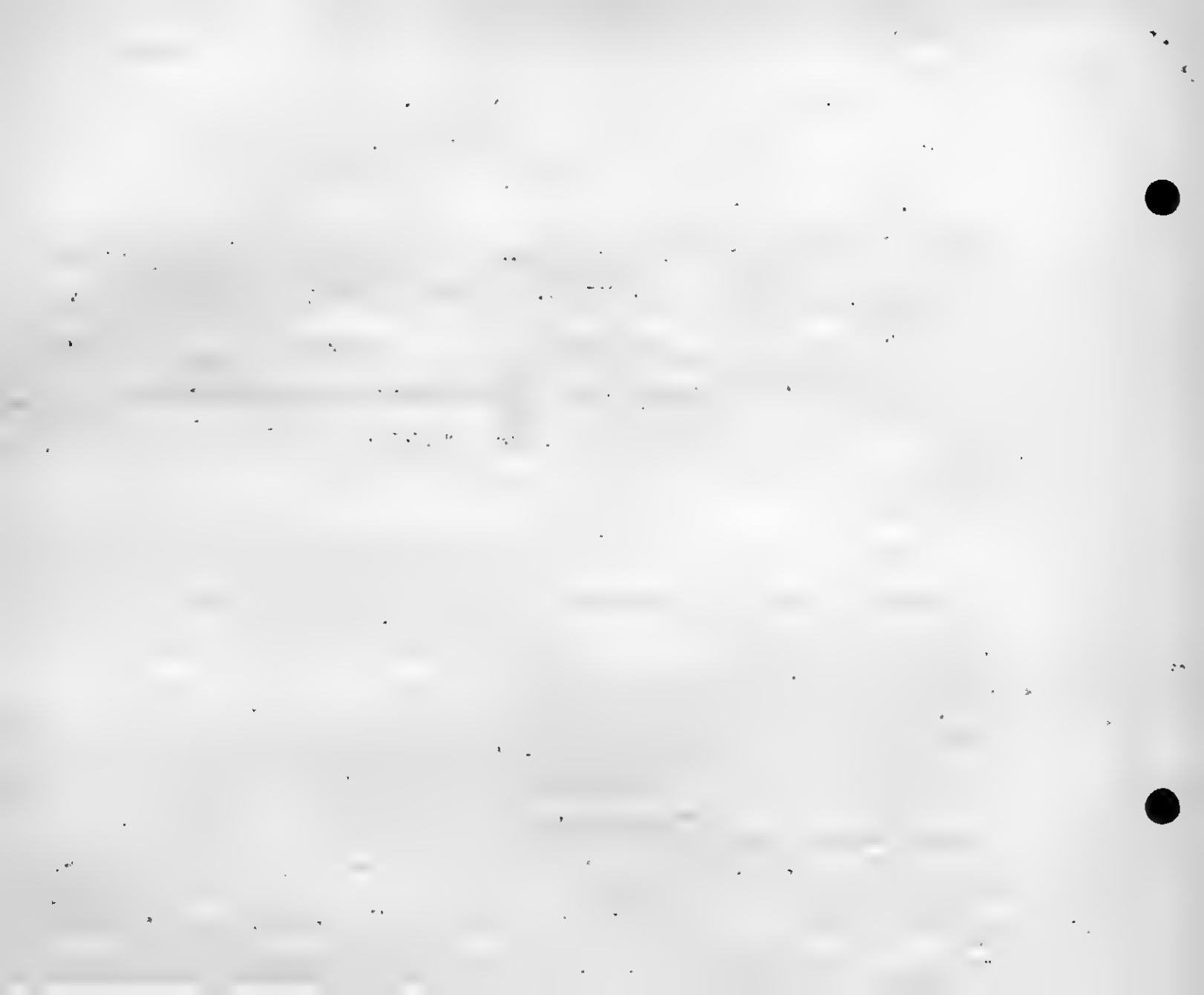
01023

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01022

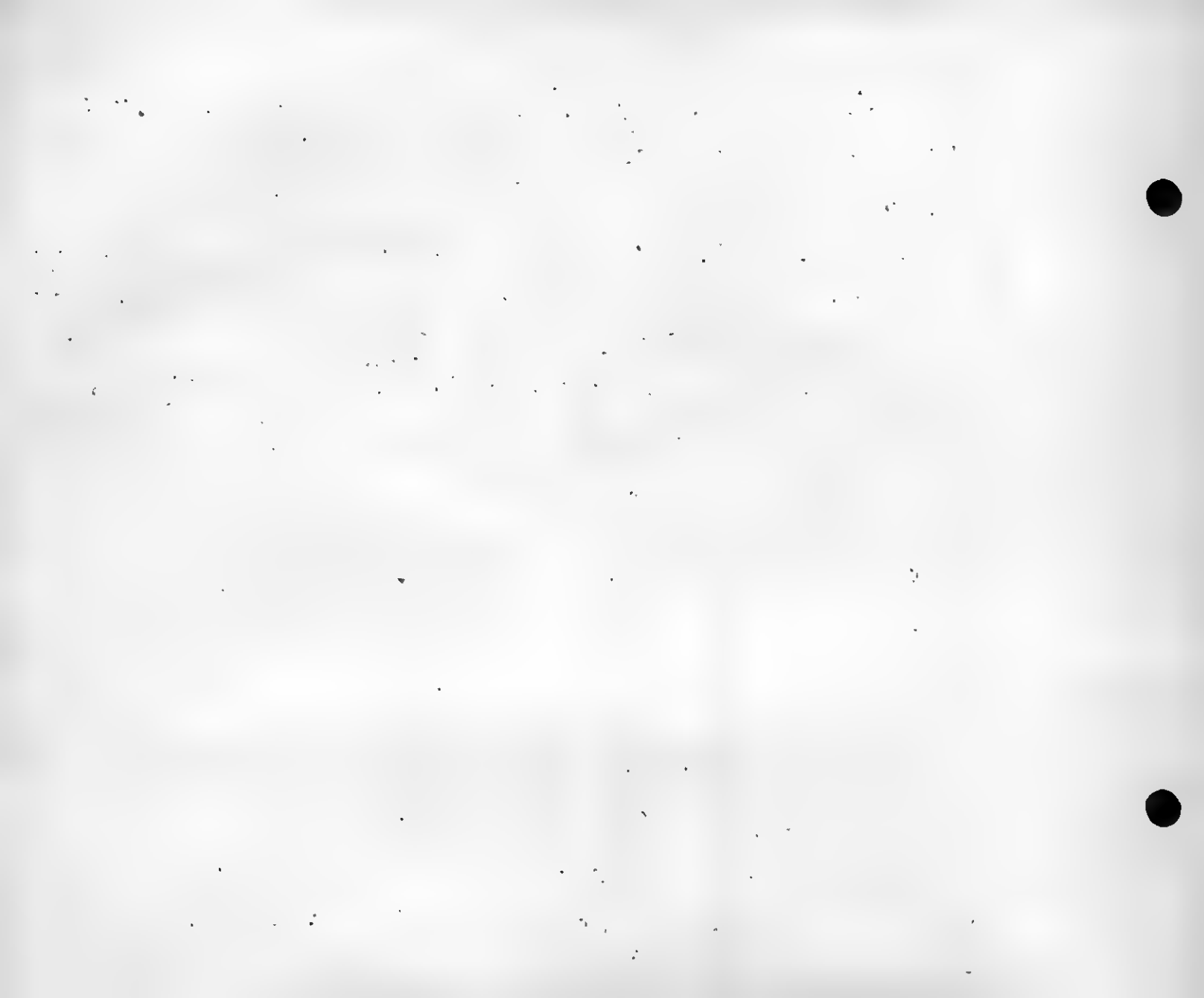
1. DECEASED-NAME (Type or print) DOUGLAS			First G. Middle PUTNAM JR. Last			2a. DATE OF DEATH Month January Day 13 Year 1968			2b. HOUR 4:30a M					
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH 22 May 1911			6. AGE (In years last birthday) 56 YRS			F. UNDER 1 YEAR MONTHS DAYS HOURS MIN. 		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford			Md.		
10. CITY OR TOWN OF DEATH Aberdeen Proving Ground			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kirk Army Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Military (Ret)			12b. KIND OF BUSINESS OR INDUSTRY U.S. Army					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Havre de Grace			13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			13e. STREET AND NUMBER (Rural) Westwood Manor		
14. FATHER'S NAME First Douglas Middle G. Last Putnam Sr.			15. MOTHER'S MAIDEN NAME First Magdalen Middle Last Ohlinger											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) Yes WW-II			16b. SOCIAL SECURITY NO 212-38-7953			17. INFORMANT Wife, Same as 13, a,b,c, & e			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) 4109 CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State 								
22a. I certify that (I) (this hospital) attended the deceased from 13 January 1968 to 13 January 1968 , that (I) (we) lost saw the deceased alive on 13 January 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Thomas J. Fraher, M.D.								DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 13 January 1968				
22d. PHYSICIAN'S NAME (Type) Thomas J. Fraher, M.D.								22e. ADDRESS KAH, Aberdeen Proving Ground, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 16 Jan. 1968			23c. NAME OF CEMETERY OR CREMATORY Churchville Presbyterian			23d. LOCATION (City or Town) (County) (State) Churchville, Maryland					
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001						ADDRESS			25a. REC'D BY REGISTRAR JAN 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>01024</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Items 5 & 6 Film G397 1/24/68 kk</div> <div>CERTIFICATE OF DEATH</div> <div>01023</div>											
1. DECEASED NAME (Type or print) Rose (none) Richards						2a. DATE OF DEATH Month January Day 11 Year 1968			2b. HOUR 3A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 1898 NOVEMBER 2, 1911		6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Ireland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md					
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Homemaker		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Res. place before admission) STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY Y/N <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 724 Linwood Ave.		
14. FATHER'S NAME First Middle Last OWEN Murphy				15. MOTHER'S MAIDEN NAME First Middle Last Catherine McNERNEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 081-10-62648		17. INFORMANT (Name) 838-8031 Mr. John P. Richards			Address 724 Linwood Ave. Bel Air, Maryland 21014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular thrombosis 4 days DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4 days										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 9 days 1 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cardiac DeCompensation + hypostatic pneumonia.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter: nature of injury in Part 1 or Part 2, Item 18)							
21d. WHERE INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from JAN 4, 1968 to JAN 11, 1968 , that (I) (we) lost saw the deceased alive on JAN 11, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edward C. Loo, M.D.				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/11/68			
22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.				22e. ADDRESS Havre de Grace, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE January 15, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Catholic Church Cem.			23d. LOCATION (City or Town) (County) (State) Hickory, Harford Co., Maryland				
24. FUNERAL DIRECTOR Joseph William Foster				ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR DATE JAN 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



CERTIFICATE OF DEATH

01024

31025

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Hartford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford de Grace</u>		c LENGTH OF STAY IN 1b <u>3 1/2 hrs.</u>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u>		d STREET ADDRESS <u>Box 410 Rt. 1</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary A.</u> Middle <u>Sadler</u> Last <u>Sadler</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>2</u> Year <u>1968</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug. 21, 1893.</u>
9 AGE (In years, months, days) <u>74</u> yrs.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Stain</u>	
14 MOTHER'S MAIDEN NAME <u>Barbara Butterhoff</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO <u>215-54-1501</u>		17 INFORMANT Address <u>Mr. Henry Sadler, 715 Shelley Rd. 21204</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>electrolyte imbalance</u> DUE TO <u>VIRAL Gastro Enteritis and</u> DUE TO <u>Autism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>JAN 1</u> , 19 <u>68</u> , to <u>JAN 2</u> , 19 <u>68</u> that (I) (we) last saw the deceased alive on <u>JAN 2</u> 19 <u>68</u> , and that death occurred at <u>12:25</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Dudley Phillips</u>		22b DATE SIGNED <u>1/2/68</u>	
22c PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>		22d ADDRESS <u>WILKINSON RD 21031</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>1/4/68.</u>	23c NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24 FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 4 1968</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01025

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - ABERDEEN		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - ABERDEEN - B.T.J. Trailer Camp	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 115 Inca - B.T.J. Trailer Camp		d. STREET ADDRESS 115 INCA ST.	
3. NAME OF DECEASED (Type or print) RAYMOND		4. DATE OF DEATH Month JAN. Day 3 Year 1968	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 11, 1909
9. AGE (In years last birthday) yrs. 58		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER - MACHINE SHOP		10b. KIND OF BUSINESS OR INDUSTRY ADMIN. PERRY POINT HUNGERFORD	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SCHEIB		14. MOTHER'S MAIDEN NAME ELIZABETH MOSEBURGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. 716-16-8561	
17. INFORMANT Mo. HAZEL C. SCHEIB		Address 115 INCA ST. ABERDEEN MD. 21001	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Co of Thyroid Conditions, if any, which gave rise to immediate cause (b) 11-3 (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1909 to 1968 , that (I) (we) last saw the deceased alive on 1-3-68 , and that death occurred on 1-3-68 from the causes and on the date stated above.			
22a. SIGNATURE John D. Yen		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOHN D. YEN		22d. ADDRESS HAVER DE GRACE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 6 1968	
23c. NAME OF CEMETERY OR CREMATORY HARFORD MEMORIAL		23d. LOCATION (City, town or county) (State) HARFORD CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell		25a. REC'D BY REGISTRAR JAN 8 1968	
ADDRESS Haver de Grace, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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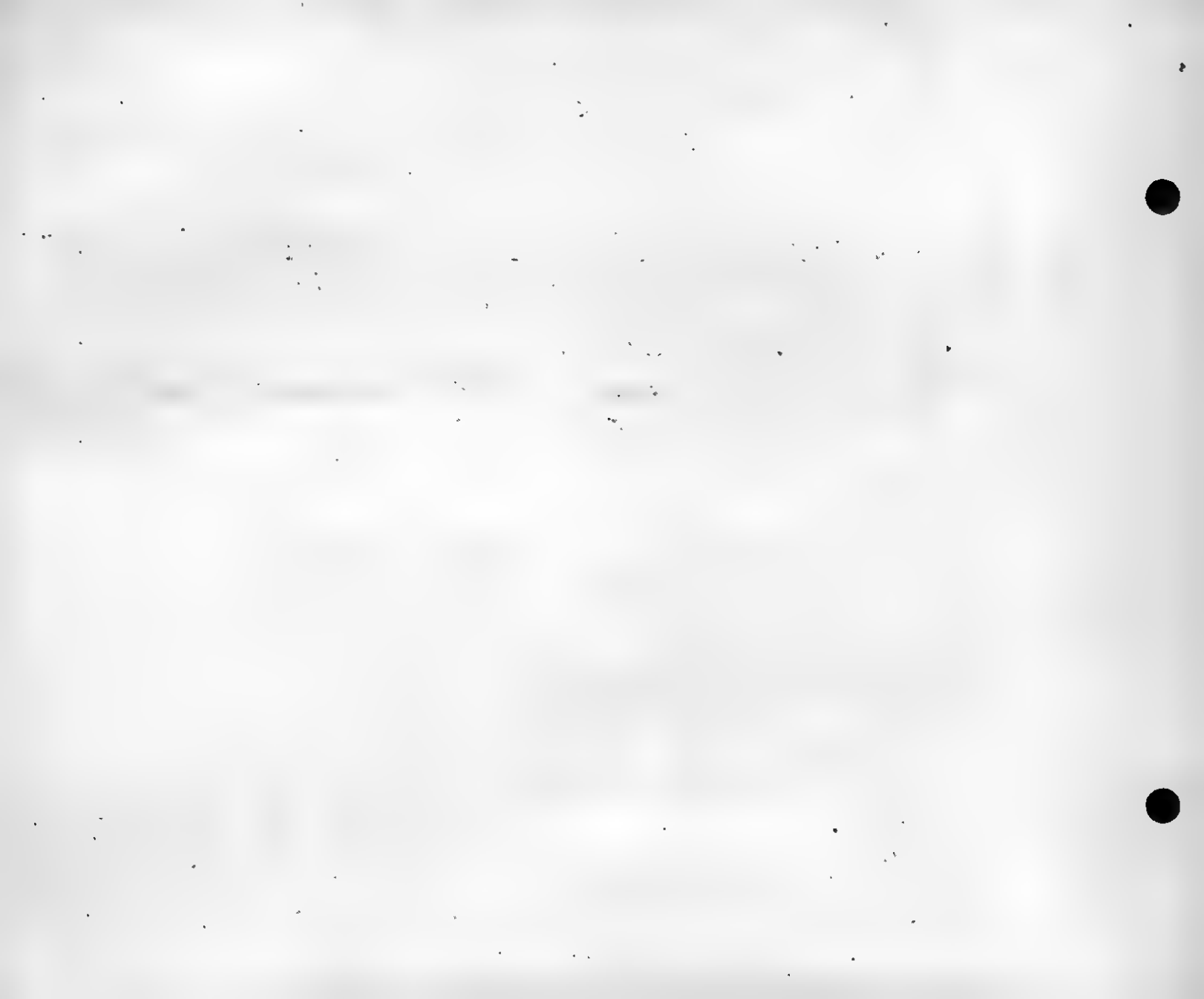
CERTIFICATE OF DEATH

01026

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. DECEASED NAME (Type or print) <i>Betty Sue Scungio</i>			2a. DATE OF DEATH Month <i>1</i> Day <i>25</i> Year <i>68</i>		2b. HOUR <i>1:45</i> PM
3. SEX <i>Female</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH <i>1-25-68</i>		6. AGE (In years last birthday) YRS. <i>0</i>	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>Hartford</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Hartford</i> Md.		
10. CITY OR TOWN OF DEATH <i>Hartford</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hartford Memorial Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Infant</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Infant</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>	13b. COUNTY <i>Hartford</i>	13c. CITY OR TOWN <i>Edgewood</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>7316 Newmarket</i>	
14. FATHER'S NAME First <i>Richard</i> Middle <i>Charles</i> Last <i>Scungio</i>		15. MOTHER'S MAIDEN NAME First <i>Bonita</i> Middle <i>McLe</i> Last <i>McLe</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Father 324 Adair St. Joppa Md 21085</i> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Prematurity</i> <i>777X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 hours</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <i>176X</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1-25, 1968</i> , to <i>1-25, 1968</i> , that (I) (we) last saw the deceased alive on <i>1-25, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>John P. Yun</i>				22c. DATE SIGNED <i>1/25/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>JOHN P. YUN</i>				22e. ADDRESS <i>HAURE DE GRACE MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>26 JAN 68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>HARTFORD MEMORIAL G.D.N.S.</i>		23d. LOCATION (City or Town) (County) (State) <i>R.D. ABERDEEN, MD.</i>	
24. FUNERAL DIRECTOR <i>Remeth & George ABERDEEN, MD 21001</i>		25a. REC'D BY REGISTRAR <i>TARRING Funeral Home</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



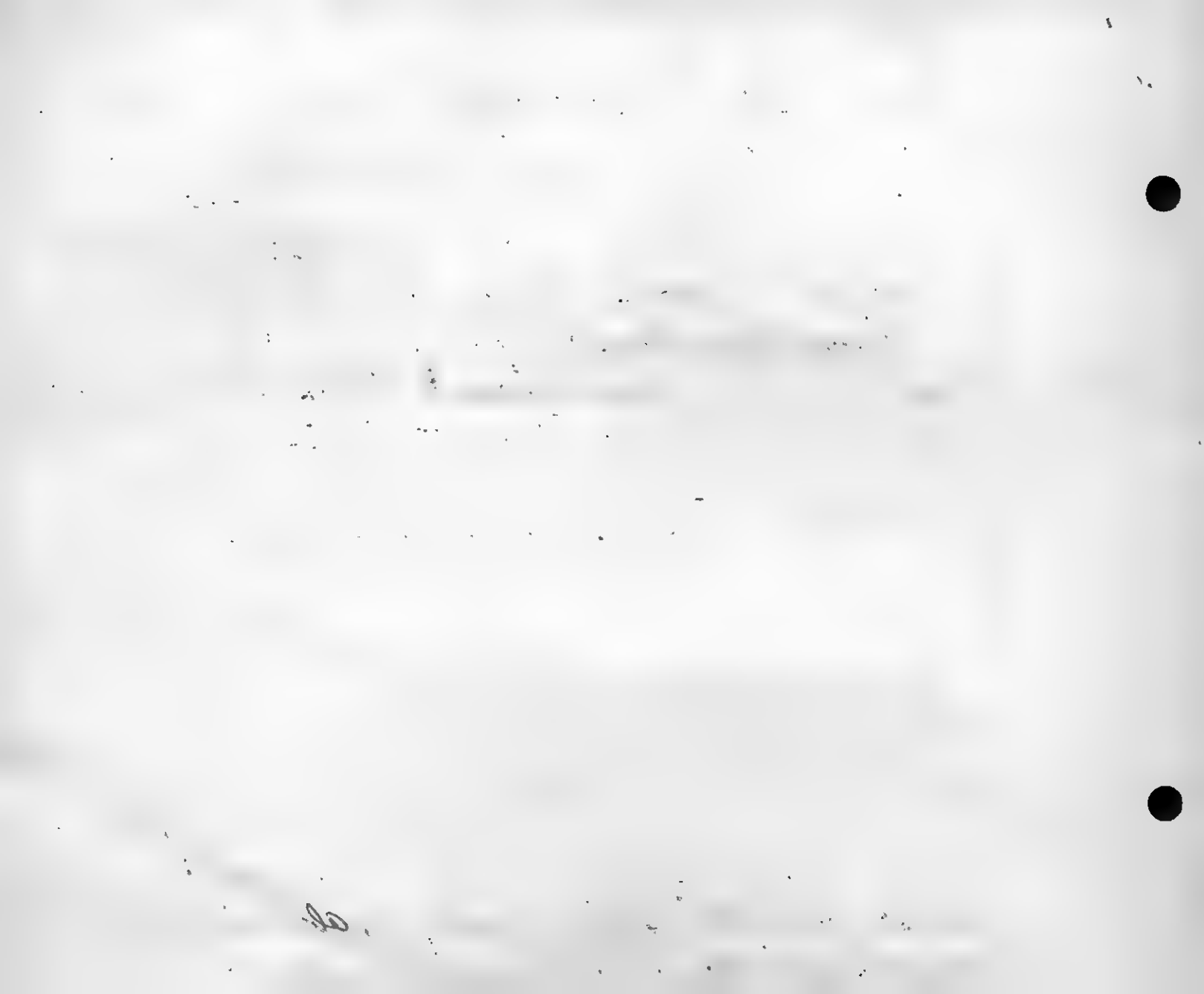
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VR 15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last <i>Thomas Elwood Shivers Jr.</i>						2a. DATE OF DEATH Month Day Year <i>JANUARY 15 1968</i>			2b. HOUR <i>6:45 A.M.</i>			
3 SEX <i>Male</i>		4 RACE <i>Negro</i>		5. DATE OF BIRTH <i>JANUARY 13, 1968</i>			6. AGE (in years last birthday) <i>2</i>		IF UNDER 1 YEAR MONTHS DAYS <i>2</i>		IF UNDER 24 HRS. HOURS MIN <i>45</i>	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USC.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i>						
10. CITY OR TOWN OF DEATH <i>HARFORD</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HARFORD MEMORIAL HOSP.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Infant</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Infant</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Abertown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Box 171</i>			
14. FATHER'S NAME First Middle Last <i>Thomas Elwood Shivers Sr.</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Melinda MAY CALM</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>				16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Thomas E. Shivers Sr. - Box 171 Abertown Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Respiratory Failure</i> <i>7518</i> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) <i>Congenital Alveolar Dysplasia</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <i>1-13</i> , 19 <i>68</i> , to <i>1-15</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>1-15</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>George T. Stansbury</i>				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1/15/68</i>				
22d. PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>				22e. ADDRESS <i>569 Revolution St. Harford Md.</i>								
23a. BURIAL, CREMATION, or other disposal (Specify) <i>Burial</i>		23b. DATE <i>Jan 17-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>West Palmyra Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Abertown, Harford Co. Md.</i>						
24. FUNERAL DIRECTOR <i>William H. Tarrington Sr.</i>				25a. REC'D BY REGISTRAR <i>Charles Jones</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>		DATE <i>JAN 18 1968</i>				

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01024

CERTIFICATE OF DEATH

01028

1 PLACE OF DEATH a COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admision) a STATE <u>MARYLAND</u> b COUNTY <u>HARFORD</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - FOREST HILL</u>		c LENGTH OF STAY IN 1b <u>26 YRS.</u>	
d NAME OF HOSPITAL OR INST TUTION (If not in hospital, give street address) <u>ADY ROAD</u>		e STREET ADDRESS <u>ADY ROAD</u>	
3 NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>M.</u> Last <u>SINGLETON</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>9</u> Year <u>1968</u>	
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 24, 1886</u>
9 AGE (n years last birthday) yrs. <u>81</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>1</u> Hours <u>19</u> Min <u>68</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUILDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FENCES</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>DUBLIN, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM ANDERSON</u>		14. MOTHER'S MAIDEN NAME <u>DAVIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>215-16-6882</u>	
17. INFORMANT <u>MRS. GILBERT HAMILTON, FOREST HILL, MD.</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO-RESP FAILURE</u> (b) <u>CONGESTIVE HEART FAILURE</u> (c) <u>ARTERIO SCLEROTIC CARDIOVASC. DCS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4721</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u> <u>MANY YRS</u> <u>ACUTE 2 WKS</u> <u>16 YRS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1951</u>, 19<u> </u>, to <u>9 JAN</u>, 19<u>68</u>, that (I) (we) last saw the deceased alive on <u>9 JAN</u> 19<u>68</u>, and that death occurred at <u>7:45</u> P.M. from causes and on the date stated above			
22a. SIGNATURE <u>H.P. Sidwell</u>		22b. DATE SIGNED <u>1-10-68</u>	
22c. PHYSICIAN'S NAME (Type) <u>H.P. SIDWELL M.D.</u>		22d. ADDRESS <u>401 FRANKLIN ST</u> <u>BEL AIR, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JAN. 12, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT TABOR</u>	23d. LOCATION (City or Town) (County) (State) <u>HICKORY, HARFORD, MD.</u>
24. FUNERAL DIRECTOR <u>John H. Harkins, DELTA, PA.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 12 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>O'Connell</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M
20 M 1968



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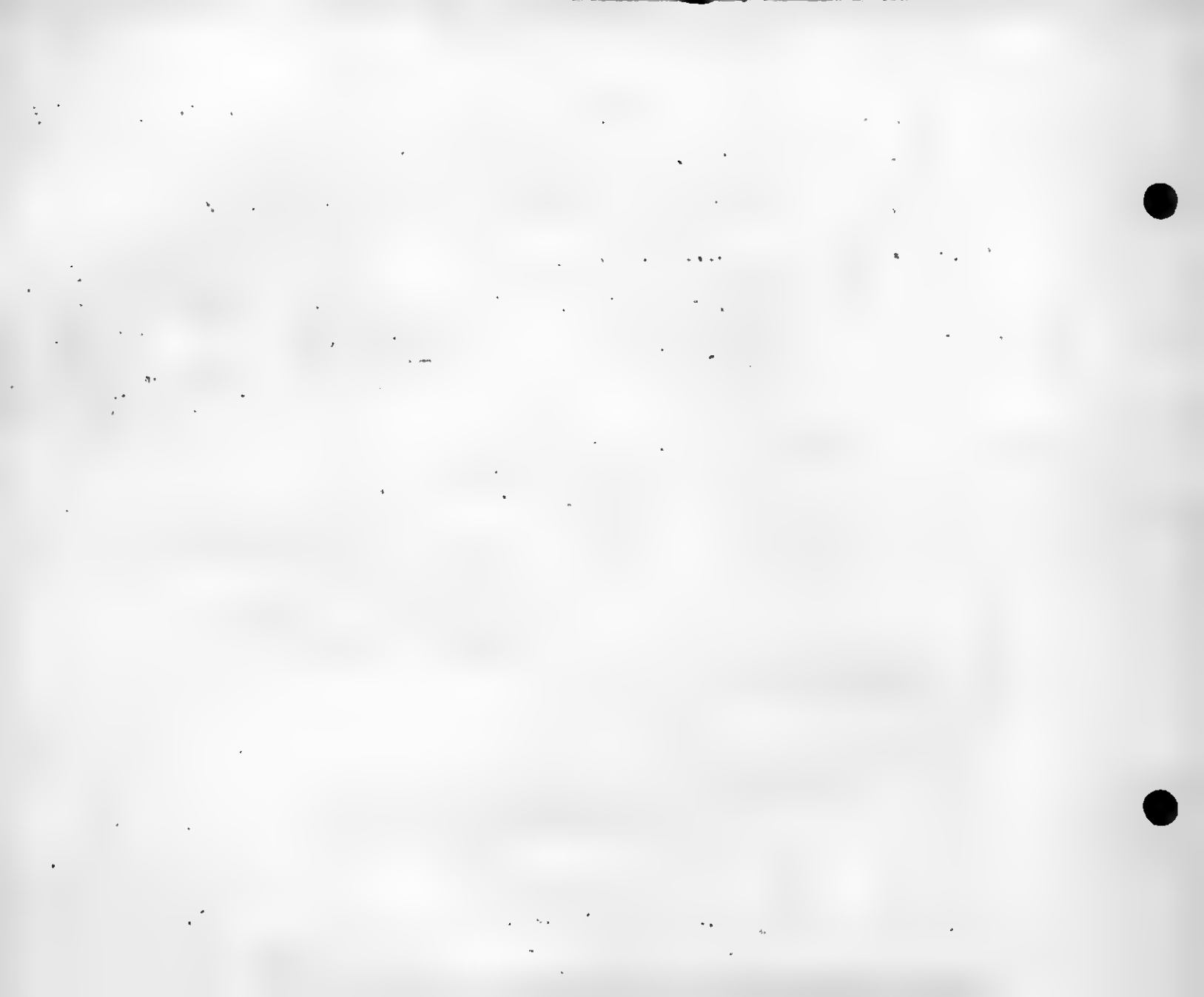
VA 15-1
30A REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01029

1 DECEASED-NAME (Type or print) <u>Ernest Reese Hugh Smith</u>			2a. DATE OF DEATH Month <u>JANUARY</u> Day <u>11</u> Year <u>1968</u>			2b. HOUR <u>2:30</u> M	
3 SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>July 26, 1886</u>		6. AGE (in years lost birthday) <u>81</u> YRS	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Hartford</u> Md.	
10. CITY OR TOWN OF DEATH <u>HARRE DE GRACE</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Hartford Memorial Hosp.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Md</u>		13b. COUNTY <u>Hartford</u>		13c. CITY OR TOWN <u>Darlington</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last <u>Samuel Thackarey Smith</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>Elizabeth McDowell</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>220-32-5530</u>	
17. INFORMANT (Daughter) <u>GL7-4271</u> Address <u>RFD #2, Paradise Farm Box 147</u> <u>Darlington, Maryland 21034</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u>		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>331X</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 10, 1968</u> , to <u>JAN 11, 1968</u> , that (I) (we) last saw the deceased alive on <u>JAN 11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. M. W. Ishak</u>		22c. DATE SIGNED <u>JAN 11, 1968</u>		22d. PHYSICIAN'S NAME (Type) <u>M. W. ISHAK, M.D.</u>		22e. ADDRESS <u>504 Lewis Street Harre-de-grace Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>January 13, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Darlington Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Darlington, Hartford Co., Maryland</u>	
24. FUNERAL DIRECTOR <u>Joseph William Fogle</u> <u>Funeral Home Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 15 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>			



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1

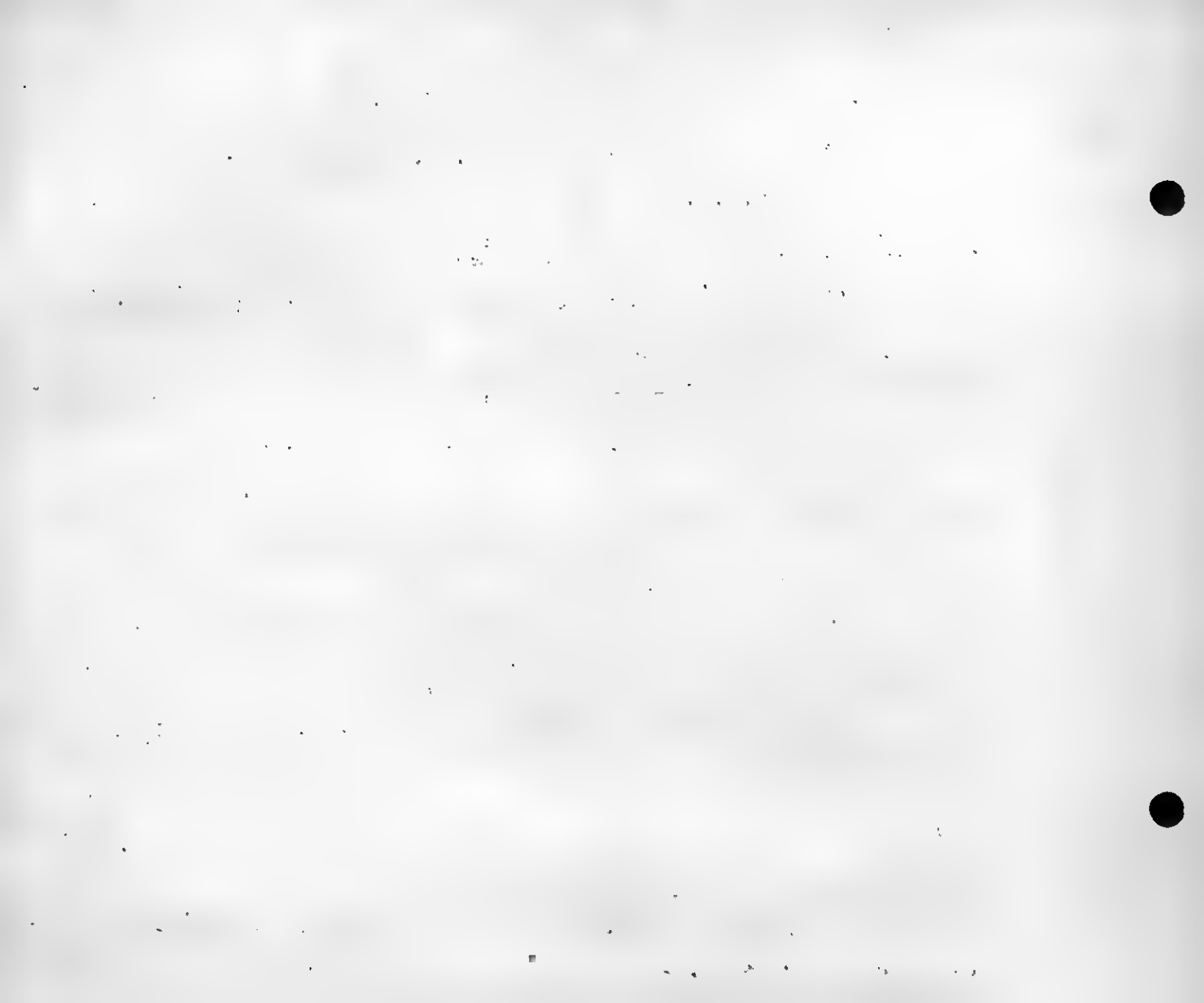
01031

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01030

1 DECEASED NAME (Type or print) ELCORYNA H Spangler			2a. DATE OF DEATH Month 1 Day 13 Year 68			2b. HOUR 6:30 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH Aug. 10, 1885		6 AGE (In years last birthday) 82 YRS.	
7a. BIRTHPLACE (State or foreign country) Scotland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford	
1d. CITY OR TOWN OF DEATH Harre-de-Grace		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE md		13b. COUNTY Harford		13c. CITY OR TOWN Abingdon		13e. STREET AND NUMBER 4017 Baker Ave	
14 FATHER'S NAME First Thomas Middle Heaton Last Heaton			15 MOTHER'S MAIDEN NAME First Ginny Middle ? Last ?				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes/no, or unknown) No		16b. SOCIAL SECURITY NO. 577-10-4425		17 INFORMANT Heleen M. Nicholas Address same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post Oper - Hip maling DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 704 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 9.560.4							
19a. DATE OF OPERATION 1/11/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hip		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell at home, several days before admission			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.) at home		21f. LOCATION Street or R.F.D. No City or Town County State 4017 Baker Ave Abingdon Harford Md			
22a. I certify that (I) (this hospital) attended the deceased from 1-4 , 19 68 , to 1-13 , 19 68 , that (I) (we) last saw the deceased alive on 1-13-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Leonard J. Ruck M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/13/68	
22d. PHYSICIAN'S NAME (Type) Leonard J Ruck Inc				22e. ADDRESS 5305 Harford Rd			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 1/17/68		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR Leonard J Ruck Inc				25a. REC'D BY REGISTRAR DATE JAN 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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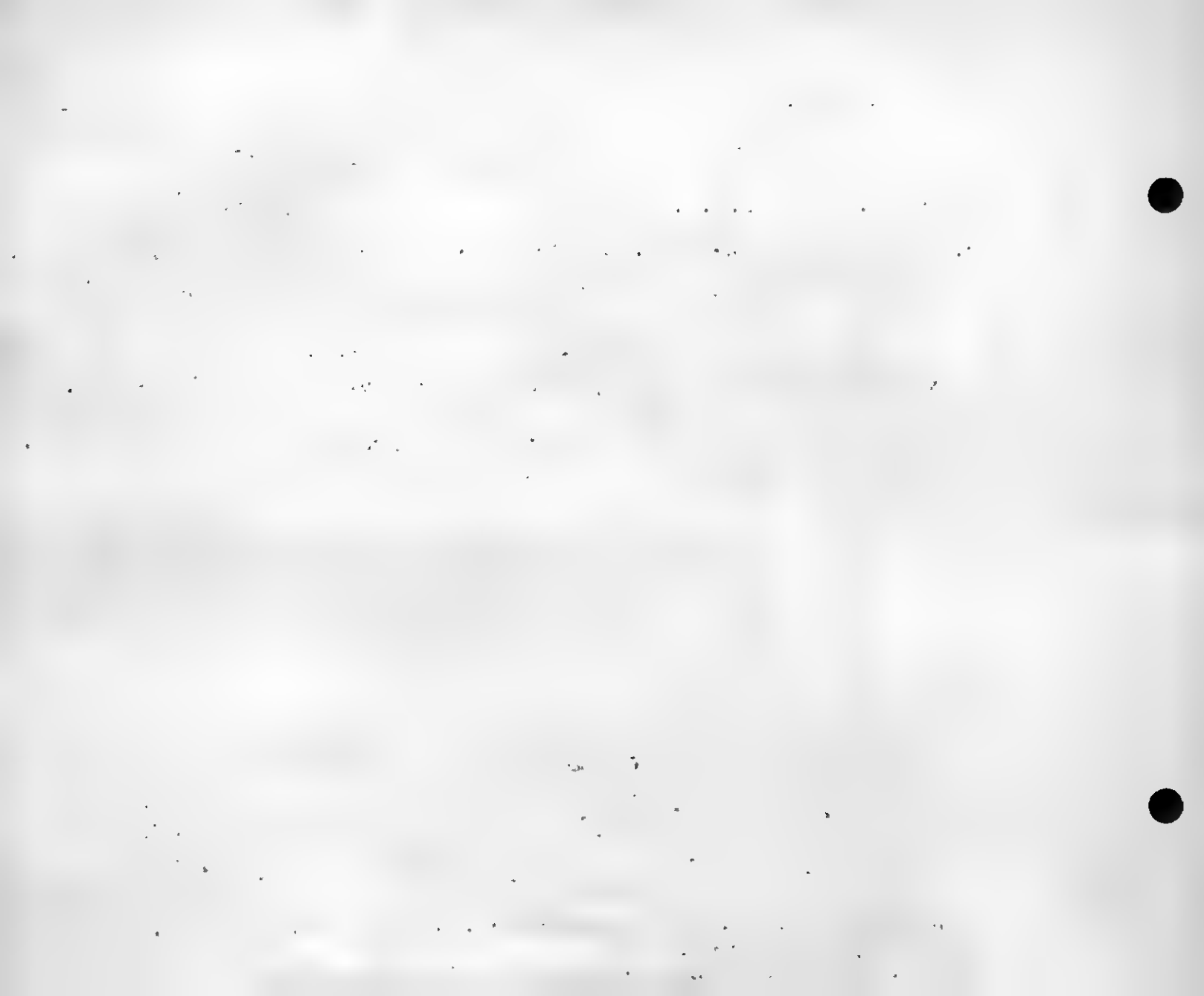
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01032

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01031

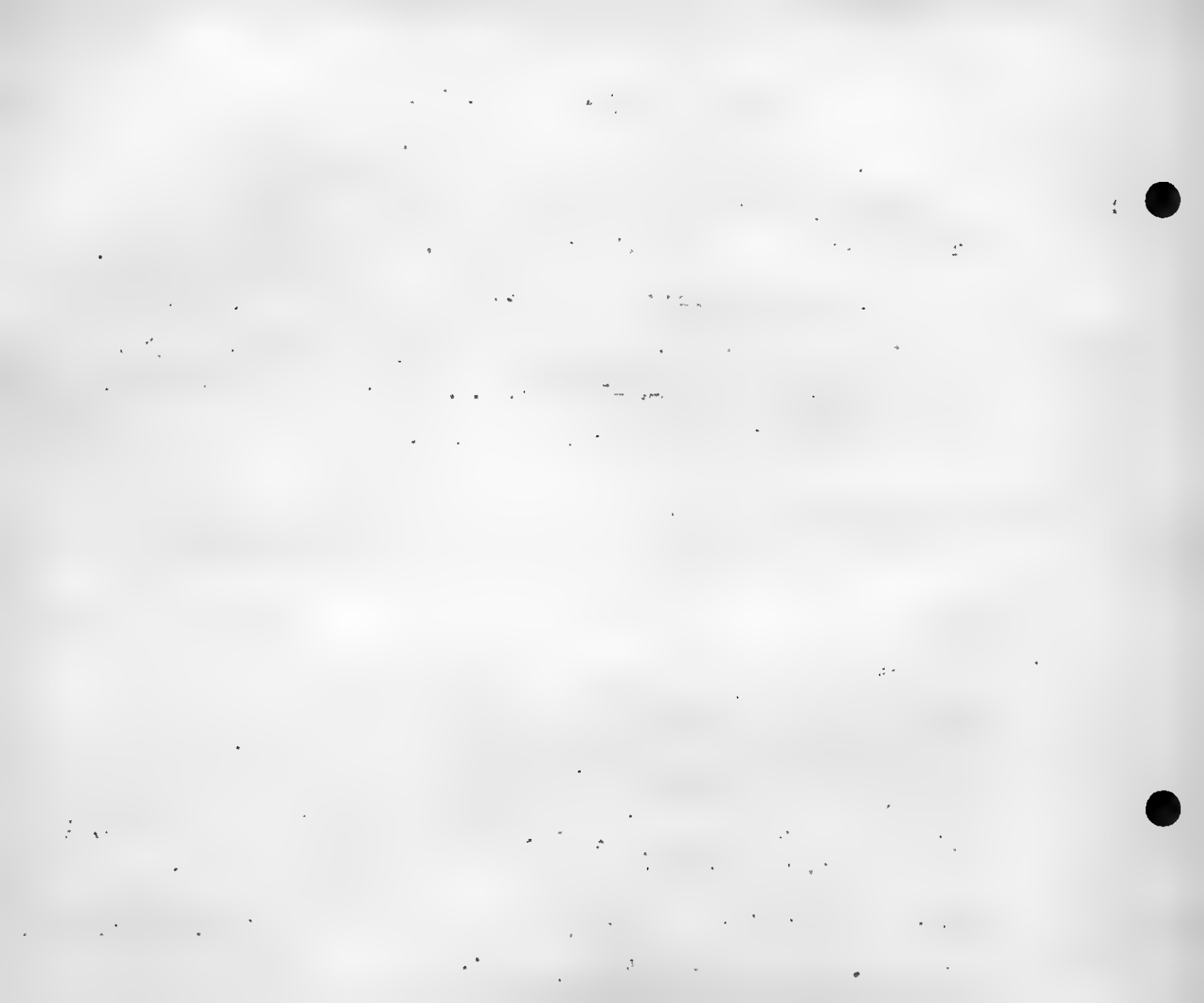
1 DECEASED NAME (Type or print) FRANK A. Steppat		2a DATE OF DEATH Month JANUARY Day 10 Year 1968		2b HOUR 2:30 M
3 SEX Male	4 RACE White	5 DATE OF BIRTH July 18, 1890	6 AGE (in years last birthday) 77 YRS.	7 UNDER 1 YEAR MONTHS 0 DAYS 0
7a BIRTHPLACE (State or foreign country) Penna.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Harford Md.	
10 CITY OR TOWN OF DEATH Havre de Grace	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hosp.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired	12b KIND OF BUSINESS OR INDUSTRY Westinghouse	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b COUNTY Harford	13c CITY OR TOWN Havre de Grace	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER St. John's Towers Apt 407
14 FATHER'S NAME First Leo Middle Steppat Last Amelia	15 MOTHER'S MAIDEN NAME First Amelia Middle Steppat Last Amelia			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)	16b SOCIAL SECURITY NO. Unknown	17 INFORMANT Address Anne Steppat, Havre de Grace, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) A.S. C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 2 years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e PLACE OF INJURY (AT HOME, FARM STREET, FACTORY) OFFICE BUILDING, ETC	21f LOCATION Street or R.F.D. No. City or Town County State		
22a I certify that (I) (this hospital) attended the deceased from JAN 10, 1968 , to JAN 10, 1968 , that (I) (we) lost the deceased alive on JAN 10, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b SIGNATURE Edward C. Loo, M.D.	DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c DATE SIGNED 1/10/68	
22d PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.	22e ADDRESS Havre de Grace, Md.			
23a BURIAL, CREMATION, REMOVAL Burial	23b DATE Jan. 13, 1968	23c NAME OF CEMETERY OR CREMATORY Glenwood Mem. Garden	23d LOCATION (City or Town) (County) (State) Broomall, Pa.	
24 FUNERAL DIRECTOR Lee A. Patterson & Son	ADDRESS Perryville, Md.	25a REC'D BY REGISTRAR Charles Judge	25b REGISTRAR'S SIGNATURE Charles Judge	
DATE JAN 15 1968				



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Mary Whitaker XXX Twining						Month 1 Day 21 Year 68		8:05A	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years)		IF UNDER 1 YEAR	
Female		W		8/1/1883		84 YRS.		MONTHS DAYS HOURS M.N.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		USA				Harford			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		Education	
Havre de Grace		Citizen Nursing H.		School teacher					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland		Harford		Forest Hill		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rock Spring Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Charles Whitaker			Mary Francis Wilson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			219-28-5280		Mr. R.G. Tucker		Forest Hill, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1538 Ca of Colon									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1538									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
A.S.C.V.D.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 7/13, 1967, to 1/21, 1968, that (I) (we) last saw the deceased alive on 1/21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
Willard Hudson						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		1/21/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Dr. Willard Hudson				Forest Hill, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/23/1968		Rock Spring		Forest Hill, Harford, Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Charles E. Kurtz Jarrettsville, Md.				DATE JAN 23 1968		J. Charles Judge			



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VR A15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
Charles Columbus Vaughn						January 8, 1968		5A. M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male		White		March 17, 1885		82 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Willis, Va.		U.S.A.				Harford County, Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Bel Air		35 West Gordon Street		Developer		Real Estate			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Harford		Bel Air				35 West Gordon Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Columbus P. Vaughn			Julia Hatcher						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT (Name and address)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 410.7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>42.1</u> (b) <u>Seminal prostatic disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>			
No		218-32-1534		Mr. Hugh C. Vaughn		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs 2-4 days			
				Address 35 W. Gordon St. Bel Air, Md. 21014					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Heart disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan. 8, 1968, to Jan. 8, 1968, that (I) (we) last saw the deceased alive on Jan. 8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Charles Richardson, Jr.</u>		22c. DATE SIGNED Jan. 8, 1968		22d. ADDRESS 304 Maitland Ave., Bel Air, Md. 21014					
22e. PHYSICIAN'S NAME (Type)		22f. ADDRESS		22g. REC'D BY REGISTRAR		22h. REGISTRAR'S SIGNATURE			
Charles Richardson, Jr., M.D.		304 Maitland Ave., Bel Air, Md. 21014		DATE JAN 10 1968		<u>Charles Judge</u>			
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan. 10, 1968		Bel Air Memorial Gardens		Bel Air, Harford Co., Md.		21014	
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. CITY OR TOWN		24c. STATE			
<u>Joseph William Foster</u>		W. Broadway & Williams Bel Air, Maryland 21014		Bel Air		Maryland			

I have been thinking of you
and wondering how you are getting on.
I hope you are well and happy.
I have been very busy lately,
but I will try to write to you
more often. I have been thinking
of you and wondering how you are
getting on. I hope you are well
and happy. I have been very busy
lately, but I will try to write to
you more often.

I hope you are well and happy.
I have been very busy lately,
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of you and wondering how you are
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and happy. I have been very busy
lately, but I will try to write to
you more often.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-103. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01035	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										01010	
1 DECEASED NAME (Type or Print)			First M dle Last			2a DATE KNOWN OF ESTI DEATH			2b HOUR		
JOSEPH O.			VIDE MALTAIS			Month Day Year			1 31 19 68 8:30		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (n years est birthday)	7 F UNDER 1 YEAR	8 F UNDER 24 HRS	2c DATE PRONOUNCED DEAD			2d HOUR		
Male	white	Dec. 18, 1893	74 YRS	MONTHS	DAYS	Month Day Year			January 31 19 68 8:30a		
7a BIRTHPLACE (State or country)		7b CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Maine NEW HAMPSHIRE		U.S.A.				Harford					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Edgewood			Mortation Inn,			Chief Steward			Merchant Mar		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before)			13b COUNTY			13c CITY OR TOWN			13d INS DE CITY LIMITS?		
New Hampshire						Manchester			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e STREET AND NUMBER					
First M dle Last			First Middle Last			425 Hayward St.					
Joseph Maltais			Armeme Bosse								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS		
No			005-24-2123			WM Letendre Funeral Service			196 Manchester St		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Arteriosclerotic Cardiovascular</u> DUE TO, OR AS A CONSEQUENCE OF <u>Disease</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>DUE TO, OR AS A CONSEQUENCE OF</u>											
(c) <u>DUE TO, OR AS A CONSEQUENCE OF</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
175A											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
CAUSE OF DEATH			P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				January 31, 1968			
Edward F. Wilson, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c LOCATION (City or Town) (County) (State)			
Burial-Removal 1/31/68				Letendre F. H.				Manchester, New Hampshire			
24. FUNERAL DIRECTOR				25a REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Wm. Cook-Brooks, Inc. 1217 St. Paul St. Balto.				DATE FEB 1 1968				Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

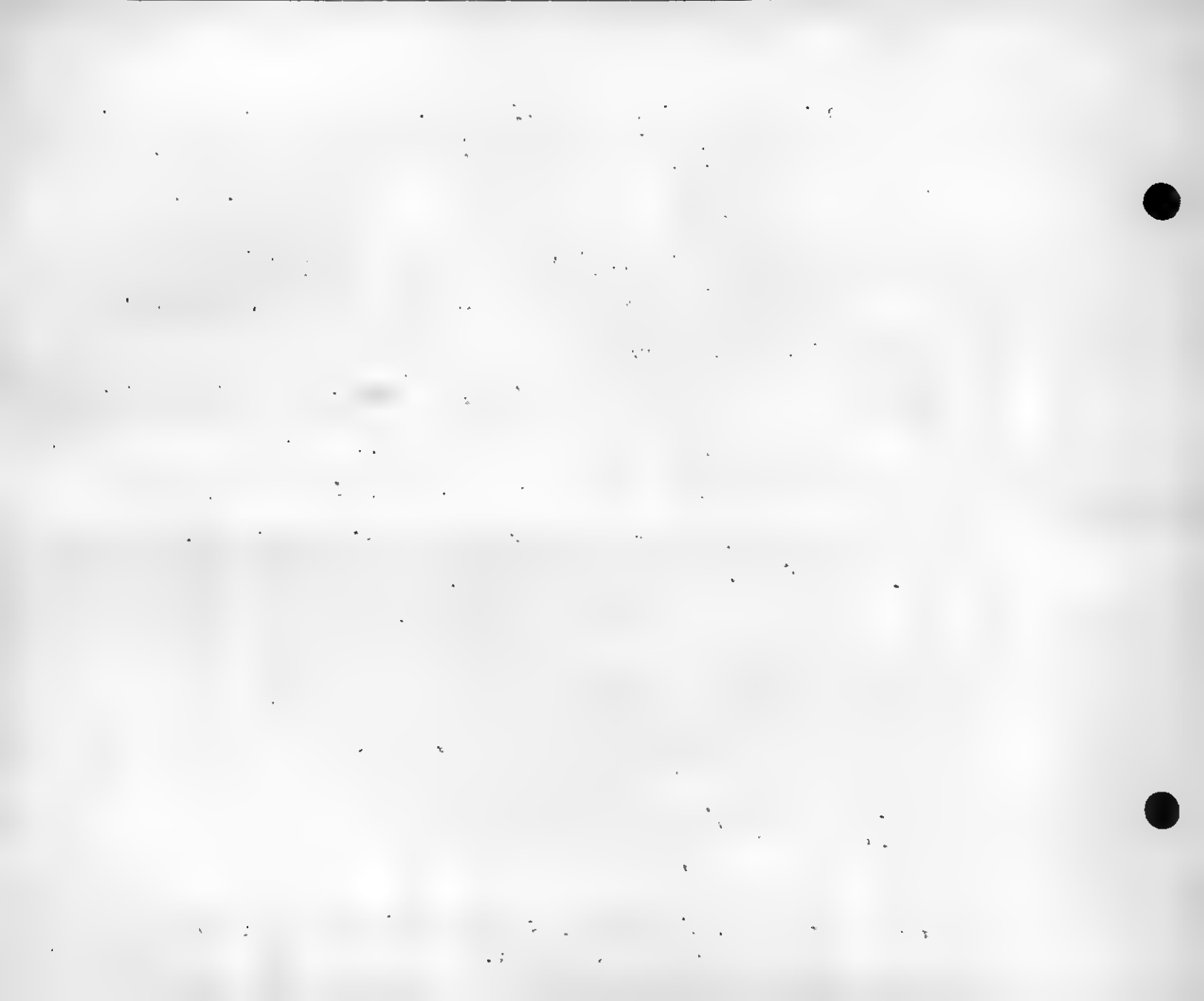
01037

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01034

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Lisa Gay Waddell</i>			2a. DATE OF DEATH Month <i>1</i> Day <i>11</i> Year <i>68</i>			2b. HOUR <i>7:30 PM</i>			
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>9-10-66</i>		6 AGE (In years last birthday) <i>1</i> YRS. <i>4</i> MONTHS <i>7</i> DAYS		IF UNDER YEAR IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>md.</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Harford</i>			
10. CITY OR TOWN OF DEATH <i>Harford</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Infant</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Infant</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>md</i>		13b COUNTY <i>Harford</i>		13c CITY OR TOWN <i>Aberdeen</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>19 8th Street</i>	
14. FATHER'S NAME First <i>Raymond</i> Middle <i>Herbert</i> Last <i>Waddell</i>			15. MOTHER'S MAIDEN NAME First <i>Margaret</i> Middle <i>Childress</i> Last <i>Childress</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b SOCIAL SECURITY NO. <i>—</i>		17 INFORMANT <i>Raymond Waddell - 19 8th St Aberdeen</i>		Address <i>md.</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hydrocephalus treated by shunt</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>question with obstruction of shunt, increased intracranial pressure & cerebellar pressure</i> DUE TO, OR AS A CONSEQUENCE OF PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Spinal fluid & cerebellar surgery</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>weeks</i>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPOST? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1-10-68</i> , to <i>1-11-68</i> , that (I) (we) last saw the deceased alive on <i>1-11-68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Richard J. Cullen</i>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>Jan 12, 1968</i>			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>Jan 12 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mount Vista Cemetery</i>		23d. LOCATION (City or town) (County) (State) <i>Bluefield West Virginia</i>			
24. FUNERAL DIRECTOR <i>Walter Henderson Jr. Tarrytown Funeral Home Aberdeen, md.</i>				25a. REC'D BY REGISTRAR DATE <i>JAN 15 1968</i>		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>			



01036

CERTIFICATE OF DEATH

01035

1 PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Whiteford		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kerr Road		d. STREET ADDRESS Kerr Road	
3 NAME OF DECEASED (Type or print) HAZEL MARGARET WATKINS		4 DATE OF DEATH Month January Day 14 Year 1968	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1918
9. AGE (In years last birthday) yrs 49		IF UNDER 1 YEAR Months 1 Days 14 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Cardiff, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James M. Stauffer		14. MOTHER'S MAIDEN NAME Edna Parry	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 218-03-8089	
17. INFORMANT E. Famous Watkins, Whiteford, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 100.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary in Ovary DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1967 to Jan 14, 1968 , that (I) (we) last saw the deceased alive on Jan 14, 1968 , and that death occurred at 12:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE Josiah A. Hunt		22b. DATE SIGNED Jan. 15, 1968	
22c. PHYSICIAN'S NAME (Type) Josiah A. Hunt M.D.		22d. ADDRESS Delta, Penna.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 17, 1968	
23c. NAME OF CEMETERY OR CREMATORY Slate Ridge		23d. LOCATION (City or Town) (County) (State) Delta, York Co., Penna.	
24. FUNERAL DIRECTOR John H. Hawkins		25a. REC'D BY REGISTRAR Jan 18 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

OR

VR A 5ME
10M REV 768

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or Print)			First MARY Middle ALICE Last WHITE			2a DATE KNOWN OF DEATH		2b HOUR		
3 SEX Female			4 RACE White		5 DATE OF BIRTH 11-10-05		6 AGE 62 YRS		2c DATE PRONOUNCED DEAD Month JAN Day 21 Year 1968	
7a BIRTHPLACE (State or foreign country) Alabama			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford		
10. CITY OR TOWN OF DEATH Havre de Grace			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sales-Clerk		12b KIND OF BUSINESS OR INDUSTRY Pharmacy & News-Stand		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland			13b COUNTY Harford			13c CITY OR TOWN Aberdeen		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME First William Middle Powell Last Cain			15 MOTHER'S MAIDEN NAME First Mary Middle Alice Last Norris			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				
16b SOCIAL SECURITY NO 407-30-1637			17 INFORMANT Donald E. White, Box 36, Aberdeen, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive cv Disease</u> 4130 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , (Inspection <input checked="" type="checkbox"/> , (Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Gerald C. Palmer			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 1-22-68		
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.			ADDRESS (Street, city, town, or county) Bel Air, Maryland							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 24 Jan. 68		23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Aberdeen, (Harford) Md.			
24 FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001						25a REC'D BY REGISTRAR DATE JAN 25 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print) Leo James Widdoes			2a DATE KNOWN OF DEATH ESTIMATED 1-6-68			2b HOUR		M	
3 SEX M	4 RACE W	5 DATE OF BIRTH Apr. 8, 1915	6 AGE (In years at birthday) 52 1/2 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month January Day 6 Year 68		2d HOUR	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Hartford		Md	
10 CITY OR TOWN OF DEATH Hartford		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hartford Memorial Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Civilian Police, Gov.		12b KIND OF BUSINESS OR INDUSTRY		U.S.	
13a USUAL RESIDENCE (Where deceased lived, if not institution residence before admission) STATE Maryland		13b COUNTY Hartford		13c CITY OR TOWN Joppa		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 304 Magnolia Rd.	
14 FATHER'S NAME First Thomas Middle M. Last Widdoes			15 MOTHER'S MAIDEN NAME First Olga Middle Olson Last						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b SOCIAL SECURITY NO 215-01-1497		17 INFORMANT ADDRESS Joppa, Md. Mrs. Marjorie Widdoes, 304 Magnolia Rd.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Gerald E. Palmer M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bela A. ... M.D.			22b DATE SIGNED 1-6-68			
EXAMINER'S NAME (Type) Gerald E. Palmer - M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 1/9/68		23c NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park		23d LOCATION (City or Town) (County) (State) Elkton, Md.			
24 FUNERAL DIRECTOR Ralph E. Hick				25a REC'D BY REGISTRAR DATE JAN 11 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01040

CERTIFICATE OF DEATH

01038

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me when I direct, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cardiff		c. LENGTH OF STAY IN lb 71 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chestnut Street		e. STREET ADDRESS Chestnut Street	
3. NAME OF DECEASED (Type or print) First Middle Last JANE HARRIET WILLIAMS		4. DATE OF DEATH Month Day Year January 6, 1968	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1872
9. AGE (In years last birthday) yrs. 95		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) West Bangor, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Jones		14. MOTHER'S MAIDEN NAME Ellen Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Edward Stewart, Cardiff, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 486X IMMEDIATE CAUSE (a) Bronchial Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 477X (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis & Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 6, 1968 , to Jan 6, 1968 , that (I) (we) last saw the deceased alive on Jan 6, 1968 , and that death occurred at 9 P.M. from causes and on the date stated above.			
22a. SIGNATURE Josiah A. Hunt M.D.		22b. DATE SIGNED Jan. 8, 1968	
22c. PHYSICIAN'S NAME (Type) Josiah A. Hunt M.D.		22d. ADDRESS Delta, Pa.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 9, 1968	
23c. NAME OF CEMETERY OR CREMATORY Slateville		23d. LOCATION (City or Town) (County) (State) Delta, York Co., Pa.	
24. FUNERAL DIRECTOR John H. Harkins		25a. REC'D BY REGISTRAR Jan 10 1968	
ADDRESS Delta, Pa.		25b. REGISTRAR'S SIGNATURE DeLanta Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01041

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01039

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year				2b. HOUR
THOMAS		DAVID	WITMER		1 8 1968				10: M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	Oct. 4, 1967	3 YRS 4	3 4		1 8		1 8 1968	10: M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Harford Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Havre de Grace			Harford Memorial Hospital			None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Harford		Darlington				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Richard E. Witmer			Carolyn Nicely						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No			None		Richard E. Witmer Rt. #1, Darlington,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial pneumonitis (SDII)</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION									19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
19a. DATE OF OPERATION									19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			1-8-68			
WERNER U. SPITZ, M.D.			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			1/10/68		Bel Air Memorial Gardens		Bel Air, Harford Co		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John H. Harding			Delta, Pa.			DATE JAN 12 1968		Charles Judge	

